Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT):

The Baseline Survey 2004

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Institute for Population and Social Research
Mahidol University
April, 2005

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Preface

In many countries, including Thailand, where the expansion of the AIDS epidemics have slowed, research and programmatic attention has shifted to issues of care and support for those persons having with HIV/AIDS. Prevention activities have been accorded a lower priority. There is an increasing realization, however, that prevention activities must always be at the forefront of the fight against HIV/AIDS. Over time the composition and risk behaviors of populations change and hence, there is an ongoing need to identify groups of the population whose prevention needs are not being met.

The mobile population is one group where increasing attention is being focused. Of particular concern is the heightened vulnerability of migrant workers to HIV. These workers move into new environments in which their traditional support systems may not operate and where they have limited access to health education and services.

In order to fully understand the prevention needs of migrant workers data is required on the levels and types of risk behaviors they engage in, there knowledge of and perceptions towards HIV, and their access to services. This data is crucial for program planning purposes and for policy advocacy.

Raks Thai Foundation(RTF) is one of the leading organizations in the region that provides health services to migrant workers. Coordinated by Raks Thai Foundation, the PHAMIT project (The Prevention of HIV/AIDS Among Migrant Workers in Thailand) aims to increase access to health services to documented and undocumented migrant workers and their independents. Institute for Population and Social Research(IPSR) is the leading research institute in areas selected to social research linking migration and health outcomes. The combination of a strong program partner and a strong research team provides the basis for high quality research that is rooted in programs. It also means that the results of the research will be used to strengthen HIV prevention programs.

Despite best efforts, the regional HIV epidemic in Southeast Asia and in Thailand has not abated. The findings from this new baseline survey of migrant populations shows that much prevention work still needs to be done. While Thailand and its neighbors have recorded impressive advances in fighting the regional epidemic, it is clear that we cannot become complacent in this battle.

The wealth of experience that the staff of IPSR, RTF and PHAMIT project bring to problem of regional HIV epidemics and mobile populations is unmatched. IPSR is privileged to be a part of this effort and proud to be working with the Raks Thai Foundation and PHAMIT project in this endeavor. And we are grateful to the Global Fund to Fight AIDS, Tuberculosis ant Malaria (GFATM) for giving us the opportunity to continue this collaboration.

C. Kanchanachitra

Churnrurtai Kanchanachitra, Ph.D.
Director of the Institute for Population and Social Research,
Mahidol University

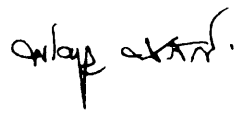
Preface
From Raks Thai Foundation

Raks Thai Foundation, a member of CARE International, was established in 1997 with the aim to implement multi-sector/integrated development for poor and marginalized populations strengthening civil society in Thailand.[1] The programs of Raks Thai Foundation are related to education, health/HIV/AIDS, natural resources management, and micro-enterprise. These programs focus on building capacity of the marginalized group to analyze problems and lead development efforts.

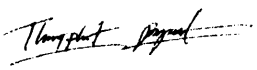
Raks Thai Foundation began working with migrant populations since 1995, then as CARE Thailand, in Samutsakorn and Samutprakarn provinces focusing on HIV prevention and reproductive health. Later this was expanded to Trat, Chantaburi and Pattani provinces. In 2003, Raks Thai Foundation saw the opportunity to scale up these programs working with other NGO partners with funding support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT) program in 22 provinces is now implemented by 6 non-government organizations and the Department of Health Systems Development, Ministry of Public Health.

Apart from direct behavioral change programs implemented by the NGO partners, the PHAMIT project aims at systematic changes of the Ministry of Public Health to increase access to health services to documented and undocumented migrant workers and their dependents. PHAMIT also engages in policy advocacy for basic rights of migrants and long term favorable policies related to migrant workers in Thailand.

Raks Thai Foundation is thankful of the Institute of Population and Social Research Institute, Mahidol University and particularly Dr Aphichat Chamratrithirong for the high quality baseline study conducted for the PHAMIT project.



Promboon Panitchpakdi
Executive Director, Raks Thai Foundation



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[1] Raks Thai Foundation evolved from CARE International Thailand, the latter of which had operated in Thailand since 1978.

Acknowledgements

First and foremost we would like to thank the Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM) and the Raks Thai Foundation for providing the support for this study. Special thanks go to Mr.Promboon Panitchpakdi, the Director of the Raks Thai Foundation, for his collaboration and provision of essential information for the development of the study.

We are grateful to the migrant workers in the border provinces of Thailand who generously shared with us their time and discussed their life experiences, attitudes and challenges. The information that they provided is priceless for the PHAMIT project and for the general public.

Special appreciation is expressed to the technical staff of the Office of Population Technical Assistance Team (OPTA), Ms.Rachita Na-Pattalung, Mr.Danai Santhakul and their data collection teams in the twenty two coastal provinces and two inland provinces in the North. We are thankful to Ms.Venuss Phoompiew for the translation of the questionnaire to the Cambodian language.

The study team would like to thank Former Director of the Institute for Population and Social Research, Associate Professor Dr.Bencha Yoddumnern-Attig who provided administrative support to this project during her directorship. Our grateful acknowledgement is due to Dr.Philip Guest for his excellent help in English editing of this report. Finally, the study team would like to express our special thanks to Associate Professor Dr.Churnrurtai Kanchanachitra, Director of the Institute for Population and Social Research for her insightful vision and promotion of HIV/AIDS evaluation and policy research.

Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT): The Baseline Survey 2004

Aphichat Chamratrithirong
Wathinee Boonchalaksi
Patama Yampeka

ABSTRACT

The Baseline Survey 2004 was carried out as part of the Evaluation and Monitoring of the Prevention of HIV/AIDS among Migrants Workers in Thailand (PHAMIT) Project. The study is supported by the Raks Thai Foundation and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM): The Global Fund/Programme on AIDS (GPA). The sample survey was conducted during April – June 2004, and covered 3,426 male and female migrant workers from Myanmar, Cambodia and Lao People's Democratic Republic. The sample represents the total target populations in the 24 provinces/sites of the PHAMIT Project. The population is based on the registered and estimated migrant workers as documented in the "Statistical Data of Irregular Migrant Worker Registration under the Resolution of the Cabinet 2001" and the "Estimates of Undocumented Marine Fisheries" by the Raks Thai Foundation.

The selection of sites, nationality and major occupational groups was undertaken using a stratified sampling design and probability proportional to size (PPS) method of selection of provinces for each of the stratified groups. At the provincial level, chain – referral methods, also known as snowball sampling, were used to recruit migrants from the selected migrants' settlement quarters and occupational groups. The survey resulted in 3,426 completed interviews, including 2,590 male and 773 female migrant workers aged 15-49. The report focuses on 2,423 migrants from Myanmar (2,026 men and 397 women) who work in the coastal provinces, 466 Cambodian migrants (428 men and 38 women) who work in the coastal provinces, and 485 migrants from Myanmar (258 men and 226 women) who work in the two inland provinces of Chiang Mai and Tak. This report excludes migrants from Lao PDR because the PHAMIT Project does not yet cover them.

The investigation focuses on socio-economic and demographic characteristics of migrant workers and highlights key outcome indicators important to the PHAMIT Project. The analysis highlights migrants' knowledge of HIV/AIDS and routes of transmission, attitudes related to HIV/AIDS, sexuality and sexual partners, condom use, life skills, awareness of right of access to health services, use of contraceptive methods, reproductive health status and access to services.

Among other things, the Baseline Survey 2004 found the sexual behavior of migrants to be of great complexity. For example, migrants working as a seafarer, or related worker, may have to live apart from their spouses for long periods of time. Consequently, they often seek casual partners. As a result, in some groups of migrant workers there is a pattern of high proportions both married men who are sexually involved with women other than their spouse. The analysis had to take this into account and stratify tabulations by different types of partners.

First of all, migrants' relationship with their regular partners or their spouses may seem to be risk-free. But their interactions are largely based on trust, which is also sometimes complicated by gender role biases and social values. The survey reveals that only about five percent of migrants ever used condoms, and this was mainly for contraception. In this respect, programs to prevent HIV transmission in the marital setting may be very difficult. Family-based intervention programs would have to be redesigned to be rigorous enough to tackle many complicated family issues.

The survey also finds that the prevalence of casual sexual relationships is very high among migrants. For example, Cambodian migrants, especially those who are single, were the most likely to have non-regular partners in the past 12 months. On average, male migrants had more than four non-regular sex partners in the last year. Only a small proportion of the non-regular partners were girlfriends or fiancés; most were sex workers. The data show that migrants also have multiple partners of different types. In terms of the program design, the spread of infectious diseases among a man's multiple partners, from sex workers to girlfriends and fiancés, could become of great concern.

The extent that male migrants visited sex workers during the past year differed by nationality of migrants and the areas where they live. Again as many as one-third of the Cambodian men, and a fairly large proportion of migrants from Myanmar who work as seafarers or related workers in the coastal provinces visited sex workers in the last year. Although the problem may be of greater magnitude, a "concentrated" program design

to tackle the epidemic in the entertainment establishments may still be a practical and a reasonable choice, where perhaps success will be more easily attained.

In order to develop appropriate programs, migrants' behavior, including the use of condom and consistency of use, was explored in detail. There are still important gaps in condom use when we look at either use with regular partners or use with non-regular partners and sex workers. Apart from the availability and accessibility of condom supplies, which appears not be a crucial factor among migrants in this study, there appear to be multiple reasons of non-use of condoms that the program intervention still has to take into account. Factors such as the awareness of the epidemic, knowledge, attitudes and preference (including distaste) of condoms, are found to be important. Most crucially, the contextual attributes, including drug use and consumption of alcohol before sexual intercourse, and lack of bargaining power and skill which impedes the extent of condom use, all have to be considered in a "multidimensional" program to promote condom use.

The Baseline Survey 2004 has provided a comprehensive overview of migrant populations and their related circumstances and behavior that is relevant to the PHAMIT implementation programs. The situation of migrants is not straightforward or static. Migrants live and interact in complex communities and in multiple patterns. This requires that intervention programs be more comprehensive, dynamic and rigorous than before. The data presented on the many aspects of migrant's behavior suggest that the program design be multidimensional and sometimes group specific. The design also needs to take into account cost-effectiveness and cultural and political sensitivity. In general terms, information and knowledge from the Baseline Survey 2004 will help in the planning and the smooth implementation of the designed intervention programs.

CONTENTS

Project processes and output will be assessed by the monitoring tools in the evaluation and monitoring framework and will focus on both the quantity and quality of the components. Program processes will be measured by the main scheduled activities which each project component will undertake. The project output component will explore the quality of the activities reaching the target population.

1.2 The Components and Objectives of the Evaluation and Monitoring Plan

Components:

1. Baseline Survey
2. Behavioral Surveys
3. Database and assessments of Program Coordinators' Reports, MOPH statistics, Field Officers' reports
4. Policy Implementation Assessment, Workshop report and Media report

Objectives:

1. To evaluate the schedule activities undertaken
2. To evaluate quantity and quality of the functional program outputs
3. To examine intermediate outcomes within the target population due to the program

Chapter 1: Introduction

1.1 Background

In 2002 the Thai government committed to a comprehensive national program to fight the HIV/AIDS epidemic at the United Nations General Assembly Specific Session (UNGASS) on HIV/AIDS. Apart from the general population, migrant workers, both legal and illegal, especially along the Myanmar, Laos and Cambodian borders are considered as critical target groups for the program against the spread of HIV/AIDS. With input from the Global Fund To Fight AIDS,Tuberculosis and Malaria (GFATM) and under the execution agency of Raks Thai Foundation, rigorous implementation programs are being scaled up to accomplish this obligation.

The baseline survey is one of the most important components of the evaluation and monitoring system to be carried out as part of the planned course of action, preferably by an affiliated but outside organization. The Institute for Population and Social Research of Mahidol University as an academic institution is undertaking this task.

The baseline sample survey focuses on the measurment of current status indicators and will be the basis for program implementation, program design/adjustment and monitoring, and for the assessment of behavioral change over time in any of the project components at the program and at the population level. With other evaluation and monitoring tools, functional output of both quantity and quality components and program process will be accessed at the program level. The baseline sample survey is being carried out for the assessment of the intermediate outcomes at the population level.

With the input from the Global Fund To Fight AIDS,Tuberculosis and Malaria, it is expected that migrant workers will have increased consistent use of condoms during causal sex and have increased access to reproductive health care services. The project outcomes will be measured by the intermediate outcome indicators such as the number of women practicing family planning on a voluntary basis, percent increase in the number of sex workers/entertainment workers reporting condom use and percent increase in the number of migrant workers reporting condom use. The increased number of migrant workers aware of rights and responsibilities is also included as key behavioral indicators to measure the success of the program.

Chapter 2: Background of the HIV/AIDS Prevention Program Among Migrant Workers

2.1 Rationale of the Program

The project addresses the vulnerability of migrant workers in Thailand to HIV infections. There are about 2.5 million migrant workers in Thailand, with most originating from Myanmar, Cambodia and Laos PDR. Currently, only slightly over 288,780 migrants are registered, dropping from 568,249 registered in 2001.[2] While some of the documented workers may have access to health information and services, there are still various systematic hindrances to full access. This includes language and culture differences, and occupational context not lending itself to health care and information. Both HIV/AIDS prevention and reproductive health care is limited for migrant workers. While there has not been systematic studies on HIV prevalence among migrant workers (HIV testing is not a requirement for documentation), previous sample testing in Trad province have shown high HIV incidence among migrant workers from Cambodia. There is also a growing number of AIDS cases reported at sites where there are Burmese migrant workers such as in Samut Sakorn province.

The project has an intermediate objective of reaching the migrant workers and related populations that have the greatest vulnerability namely – fishermen – in 22 coastal provinces. In addition the project will work in two other northern provinces where there are large numbers of factories and plantation workers. Immediate behavioral change communications interventions for HIV/AIDS prevention and reproductive health care will be applied in these 24 provinces, mainly through the programmes of 5 non-governmental organizations that have been working with migrant workers for the last 4-5 years. About 500,000 migrant workers will be covered during the 5 year period of the project.

While NGOs will take the lead in the prevention programmes, the capacity of the service units of the government and privates sectors will be strengthened with the aim of building the capacity of these organizations in implementing HIV/AIDS prevention and care services for migrant workers. This will include health personnel training workshops, translation services, and sensitizing local leaders to government policy related to HIV prevention and health care services for migrant workers. In this connection the project also aims to review existing policies related to health and social services for migrant workers and recommend policy adjustments that are in line with international accepted practices on migrant workers.

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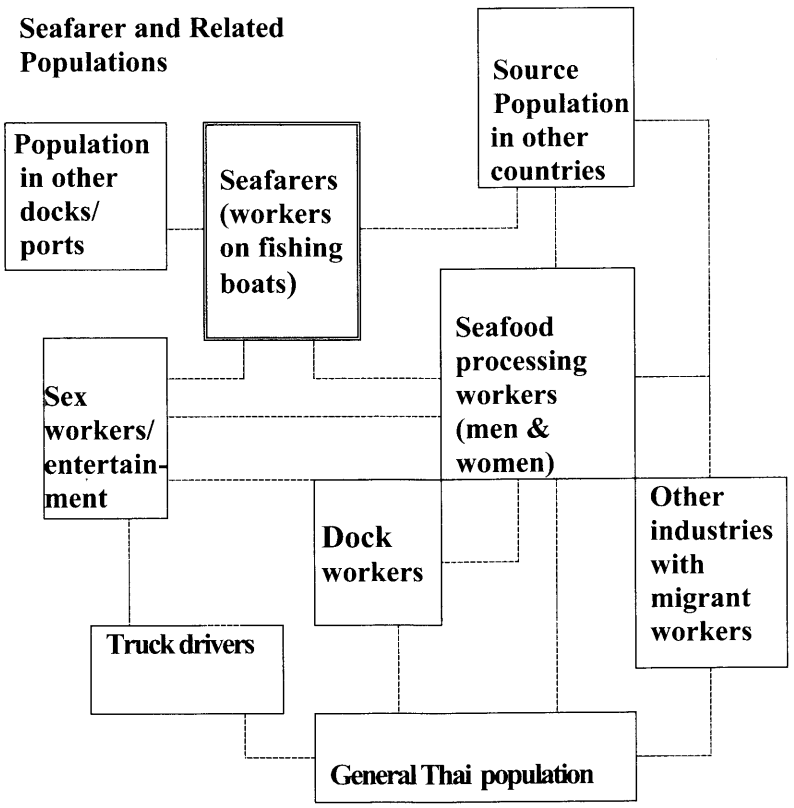
[2] "Table on Comparison of the Results of the Registration of Migrant Workers Distributed by Provinces in 2001 and 2002," document of the Office of Foreign Workers Administration, Department of Employment, Ministry of Labour and Social Welfare, 2004.



Project Goal

The project will reduce the number of new HIV infections among migrant workers in Thailand and contribute towards the reduction of HIV/AIDS in the subregion (Thailand, Cambodia and Myanmar) through behavioral change communication programs, increasing access to health and reproductive health care, information and services and by developing favorable policy for health of migrant workers

Indicators

1. HIV prevalence during surveillance exercises will be reduced by 35 percent from the level at the beginning of the project (about 7 percent among seafarers, but less among related populations).
2. Reported STI within the last 12 months will reduce by 10 percent among male workers.
3. Married couples living together and youth that are sexually active will have increased reproductive health knowledge and the number of family planning users of temporary methods will increase by 30 percent (from a base of about 30 percent of current users).

Systematic Indicator :

Government policies and long term implementation guidelines are announced that lead to favorable social conditions and respect for human rights.

2.2 Objectives and expected outcomes

Based on the problem analysis, the project is designed with four intermediate objectives that if achieved will lead to the final goal of reducing HIV prevalance.

Objectives

1. Migrant workers and related populations use condoms consistently during casual sex and practice reproductive health care.
2. Health system is favorable for migrant workers to receive health prevention and treatment services that are suitable for migrant workers.
3. There is a supportive psychosocial environment for migrant workers and their dependents.
4. Political factors support migrant workers health and treatment at the national and inter-country level.

Coverage:

The project will cover 24 provinces in Thailand. Twenty provinces are coastal provinces that have seaports and migrant workers (410,796). The other two provinces are in northern Thailand and have a large number of migrant workers working in factories and plantations (126,048).

The main focus will be on migrant workers of the reproductive age group. The project will also reach dependents of the migrant workers and their communities. The project will cover women working in the entertainment industry that are related to migrant workers.
The following gatekeepers will be involved: employers of migrant workers and entertainment industries as well as employer associations; provincial public health offices, related government and private hospitals, and health centers/clinics.

Objective 1 : Migrant workers and related populations use condoms consistently during casual sex.

Outcome/coverage indicators are

1. Seafarers (condom use)
   1.1 Migrant Workers are informed and intend to use condoms
   1.2 Condom outlets at workplace and entertainment establishments
   1.3 STI treatment services available near Workplace

2. Women receive reproductive health services (RH, PMTC)
   2.1 Women practice family planning on voluntary basis

3. Sex workers/entertainment workers negotiate for condom use

Objective 1 Description for Broad Activities

The project will have a direct behavioral change communications (BCC) component that is focused on the seafarers and related populations. This is required since there are no existing STI/HIV prevention programs that are developed for this population group. The migrant workers also come from rural areas in their own countries where there is limited educational materials and programs on AIDS prevention. This activity is based on the existing experiences of NGOs working in the area i.e., Raks Thai Foundation (RTF), World Vision Foundation of Thailand (WVFT), Program for Appropriate Technology in Health (PATH), Center for AIDS Rihgts (CAR), MAP Foundation (MAP). The activities include interpersonal contacts through small group informal training, peer education, audience research information materials, and condom distribution.

In order to reach the large number of women working in the related industries (seafood processing, entertainment, etc.) as well as the youth population that is often engaged in casual sex, the project will provide reproductive health education and services (voluntary family planning of temporary methods). The project will have specific activities for women working in the entertainment industry that will cover broader issues on health and their general livelihoods.

The project will also include employers and employer associations of migrant workers as these are the "gatekeepers" that enable health programs to reach migrant workers. Apart from employer education and joint STI/HIV prevention activities, each partner will encourage employers to set and implement healthy workplaces with HIV/AIDS prevention and non-discrimination against employees.

Objective 2 : Health system is favorable for migrant workers to receive health prevention and treatment services that are suitable for migrant workers.

Outcome/coverage indicators are

2.1 Government hospitals/health centers that serve migrant workers
  2.1.1 Government health outlets that provide prevention and care for migrant population
2.2 Private hospitals/drugstores participate in health services
2.3 Owners/employers and employer associations enable that provide health services
2.4 Staff exchanges between Thailand, Myanmar and Cambodia

Objective 2 Description for Broad Activities

During the past 4-5 years, NGOs have taken the lead in organizing HIV/AIDS prevention activities (World Vision Foundation of Thailand, Raks Thai Foundation, Center for AIDS Rigts, Program for Appropriate Technology in Health, MAP Foundation, Stella Maris and providing limited health and reproductive health services (World Vision Foundation of Thailand, Raks Thai Foundation). The advantage of NGOs is their community based approach and audience-based educational materials/activities. In addition, the government does not have a policy for providing health services and AIDS prevention for migrant workers who are not registered (undocumented). The project will change this situation by engaging government, and particularly health units, in health care and information service delivery. This is seen as favorable given the current government's decision to increase the number of migrant workers and the charge migrant workers a health insurance fee (Baht 1,200 per person per year).

This objective will lead to the incorporation of health services for migrants as part of the health system by the Department of Health Services Support, Ministry of Public Health with technical support by the Program for Appropriate Technology in Health (PATH).

The key steps in increasing the capacity of government facilities in providing health services and information include training and promoting awareness among health providers of health issues and related behaviors of the migrant workers, translation services for migrant workers, organizing services closer to the workplace through mobile teams, and encouraging involvement of the private sector.

The project will also support staff exchange between health personnel of Myanmar and Cambodia coming to Thailand. This will lead to greater cooperation between the countries and linked services in prevention and care.

Objective 3 : There is a supportive psycho-social environment for migrant workers and their dependents.

Outcome/coverage indicators are

3.1 There is community network of the migrant workers.
3.2 Children of migrant workersthat receive proper health care and education.
3.3 Migrant workers are aware of rights and Responsibilities.

Objective 3 Description for Broad Activities

The project includes the assumption that healthy behaviors among migrant workers is also associated with hope and a reasonable social and economic livelihood. Thus the project will have selected inputs aimed at improving the social contextual factors of the migrant workers. This includes community forums and activities for local community improvements.

Other activities include financial services such as savings. Group activities will be organized by youth on life skills and gender. Education programs will also be design for children who are dependents of the migrant workers.

Objective 4 : Political factors support migrant workers health and treatment at the national and inter-country level.

Outcome/coverage indicators are

4.1 Long term policy/laws reviewed, discussed and formulated
4.2 Law sensitizing of employers, government officials, media and migrant workers
4.3 Public reached by media with favorable messages
4.4 Inter-country policy dialogue and agreements on cooperation
4.5. Learning and experiences documented and shared

Objective 4 Description for Broad Activities

The current political environment related to migrant workers in Thailand is still evolving and dynamic. Policies are set on a year to year basis, although the Office for Affairs Related to Migrant Workers have been set up by the government to advice on policy issues and to develop a five year master plan.

The project will organize activities to sensitize government officials at the provincial and service level to be aware of current government policies that are related to health and basic rights. The project will also review policies and prepare policy recommendations for related policy making and policy implementation agencies.

Inter-country dialogue will be established between Thailand and the main source countries of migrant workers, aiming to form joint understanding of the health and AIDS prevention and care issues and to form joint implementation programs.

Within Thailand, the various government, non-government and international organizations related to migrant worker issues will have frequent fora to discuss the program activities, achievements and problems.

Information will also be shared with the public to produce a favorable but objective image of migrant workers and their role in the Thai socio-economic development.

Project Monitoring

Finally the project will have several monitoring, evaluation and lessons learned documentation activities that will be shared among Thai and international agencies to increase learning and understanding on the various issues.

The project is aimed at scaling up the coverage of HIV/AIDS prevention and, in some cases reproductive health care, for migrant workers particularly in the fisheries industry. The scaling up will occur through the immediate/expanded services of the NGOs and the expansion to include the public and private sector (hospitals, clinics and employers). This is based on the policy framework that supports health and HIV prevention activities for migrant workers and specific policy guidelines related to the registration of migrant workers in Thailand. The project will also rely on and strengthen regional cooperation that is based on existing ASEAN policy recommendations.

The project will include the involvement of migrant workers in the forms of :

- peer trainers
- monitoring of interventions and inputs for educational activities development
- community strengthening activities aiming promoting community networks and solving of community issues

Community participation:

The Thai community involved will include the private sector (boat owners, employers, etc.) and information dissemination to the Thai public through media channels. This is important to reduce the negative attitudes that the general population has about migrant workers that can lead to discrimination, exploitation and racial tension.

Gender equality issues:

The project will include gender issues related to the migrant population community, migrant women workers and youth/children. This will be addressed to services such as reproductive health education and services as well as through the design of project activities. This will also be seen in the interventions aimed at strengthening the role and position of women working the sex industry.

Social equality issues:

The project is connected with the larger goal of rights to health access for migrant workers and their accompanying families members (elderly, spouse, children). Other rights are linked such education rights of children, combating discrimination and exploitation of migrant workers.

Human Resources development:

Health personnel of the health outlets that are in the provinces where there are migrant workers will be the main target for skills and positive attitudes development. These skills are not medical or treatment skills, but are more skills in working in cross-cultural situations. This may include training where there is language and cultural differences, or understanding the psychosocial aspects of health care and treatment. In addition the project will initiate inter-country linkages in staff exchange activities.

Chapter 3: Methodology of the Study

Design of the Baseline Survey

The Baseline Survey for the Evaluation and Monitoring of the Prevention of HIV/AIDS Among Migrant Workers in Thailand Project (PHAMIT) is designed for use as the basis and point of reference for the upcoming assessment of project outcomes at the population level among migrant workers.

3.1 Target population

The scaled-up HIV/AIDS prevention program among migrant workers will be implemented in a total of 24 provinces in Thailand, supported by the Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM). Male and female migrant workers from Myanmar, Lao People's Democratic Republic and Cambodia are among the target populations considered for the assessment. These migrant workers, legal or illegal, were selected from their workplaces. The recruitment was undertaken in workplaces of all sizes and including informal and unregistered workplaces.

3.2 Sampling method and subject recruitment

During December 2003 and January 2004, the research team met several times to study the sampling frame, discuss and finalize the sampling methodology and operation plan of the field survey. The sampling design is described below.

The universe

The universe of the Baseline Survey was based on "Statistical Data of Irregular Migrant Worker Registration under the Resolution of the Cabinet 2001" and "Estimates of Undocumented Marine Fisheries" provided by the Raks Thai Foundation. These data on the registered and estimated migrant workers generated the total target population in all the 24 sites of the PHAMIT project. These data are available for the three nationalities of migrant workers (Myanmar, Cambodian and Laotian), occupational groups (marine fisheries, fishery-related work, factory work and others) and by provinces or the 24 PHAMIT project sites. The data are available for the 22 coastal provinces for marine fisheries and fishery-related work as well as two inland provinces (Chiang Mai and Tak) for

factory work and other work-related activities. Data on marine fisheries were not provided for each of the three nationalities. They were estimated using the same nationality distribution of the other occupational groups.

The sampling was undertaken with a stratified sampling design resulting in six stratified samples for the three nationalities and two occupational groups in the 22 coastal provinces, and two stratified samples for two occupational groups among the Burmese in the two inland provinces, Chiang Mai and Tak in the North. The 8 stratified groups are presented as follows:

1. Burmese marine fisheries in the coastal provinces
2. Burmese fishery-related work in the coastal provinces
3. Cambodian marine fisheries in the coastal provinces
4. Cambodian fishery-related work in the coastal provinces
5. Laotian marine fisheries in the coastal provinces
6. Laotian fishery-related work in the coastal provinces
7. Burmese factory work in the North
8. Burmese 'other work' in the North

For each of these stratified samples, the number of migrants to be interviewed was calculated as a proportion of the estimated population of migrant workers according to the numbers listed under the Resolution of the Cabinet 2001. For all the coastal provinces, 0.46 percent of the estimated migrant populations were drawn as the sample. For the two inland provinces, the sample consisted of 0.23 percent of the estimated migrants for each of the two provinces and each of the two occupational groups. The sample sizes of the 8 stratified populations are shown in the following table:

Stratified sample	Estimated Population (N)	Sampling fraction (percent)	Sample size (n)
1. Burmese marine fisheries in the coastal provinces	324,711	0.46	1,480
2. Burmese fishery-related work in the coastal provinces	208,010	0.46	952
3. Cambodian marine fisheries in the coastal provinces	61,911	0.46	282
4. Cambodian fishery-related work in the coastal provinces	39,680	0.46	180
5. Laotian marine fisheries in the coastal provinces	24,174	0.46	110
6. Laotian fishery-related work in the coastal provinces	15,486	0.46	71
7. Burmese factory work in the two inland provinces in the North	76,416	0.23	174
8. Burmese 'other work' in the two inland provinces in the North	125,348	0.23	288

According to this method of selection, the first six stratified samples can be analyzed individually as well as in total, because the sampling fractions are the same, i.e., 0.46 percent. The last two stratified samples can also be added together without weighting. But to add them to the first six stratified samples requires weighting.

For each of the stratified samples, based on the number of migrants distributed by provinces in the database, a sufficient number of provinces were selected for the Baseline Survey to insure the spread of the 22 provinces. As a consequence, 8 of 22 provinces were selected for the Burmese workers, and only three and one provinces were selected for the Cambodian and the Laotian respectively. For each of the first four stratified samples, selection of provinces from the 22 coastal provinces was made using probability proportional to size (PPS) as the method of selection. However, during the fieldwork, two provinces had to be replaced by provinces of equal size due to project program changes resulting from heavy out – migration or new resettlement of workers. For Laotian workers one province was purposively selected (representing the largest settlement of migrant worker population) for each of the two occupational groups.

For the coastal provinces, for each stratified sample, equal numbers of migrants were targeted for interview for each province. The number of provinces selected for each of the stratified samples, and the sample size of each of the six stratified samples for each province are presented in the following table:-

Stratified sample	Number of provinces selected	Sample size for each province	Total sample size (n)
1. Burmese marine fisheries in the coastal provinces	8	185	1,480
2. Burmese fishery-related work in the coastal provinces	8	119	952
3. Cambodian marine fisheries in the coastal provinces	3	94	282
4. Cambodian fishery-related work in the coastal provinces	3	60	180
5. Laotian marine fisheries in the coastal provinces	1	110	110
6. Laotian fishery-related work in the coastal provinces	1	71	71
7. Burmese factory work in two inland provinces in the North	2	Chiang Mai (66) Tak (108)	174
8. Burmese 'other work' in the two inland provinces in the North	2	Chiang Mai (47) Tak (241)	288

At the province level, the survey team consulted with implementers at the field office on the program area coverage in order to select migrants for interview. Due to the fact that the majority of migrant workers are undocumented, it was not possible to obtain a listing of all migrants and to draw respondents from a sampling frame. Therefore the snowball technique or chain-referral method was used to recruit respondents.

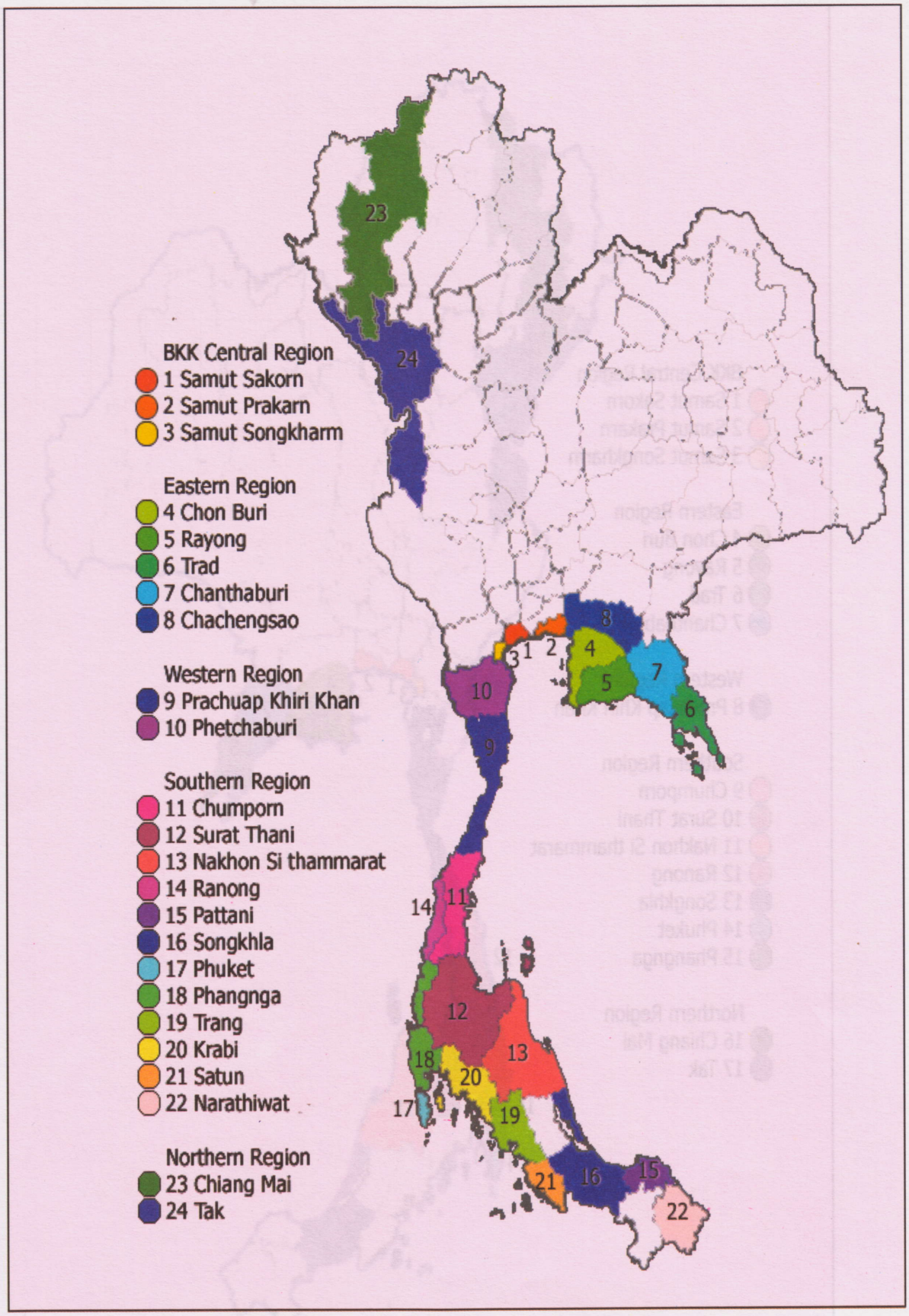
The field supervisor developed a worksheet and located "seeds" (the starting cases) and allowed them to snowball to other cases. The seeds would be placed in the program area and roughly spread out proportional to the migrants' settlement quarters. One seed would snowball to about

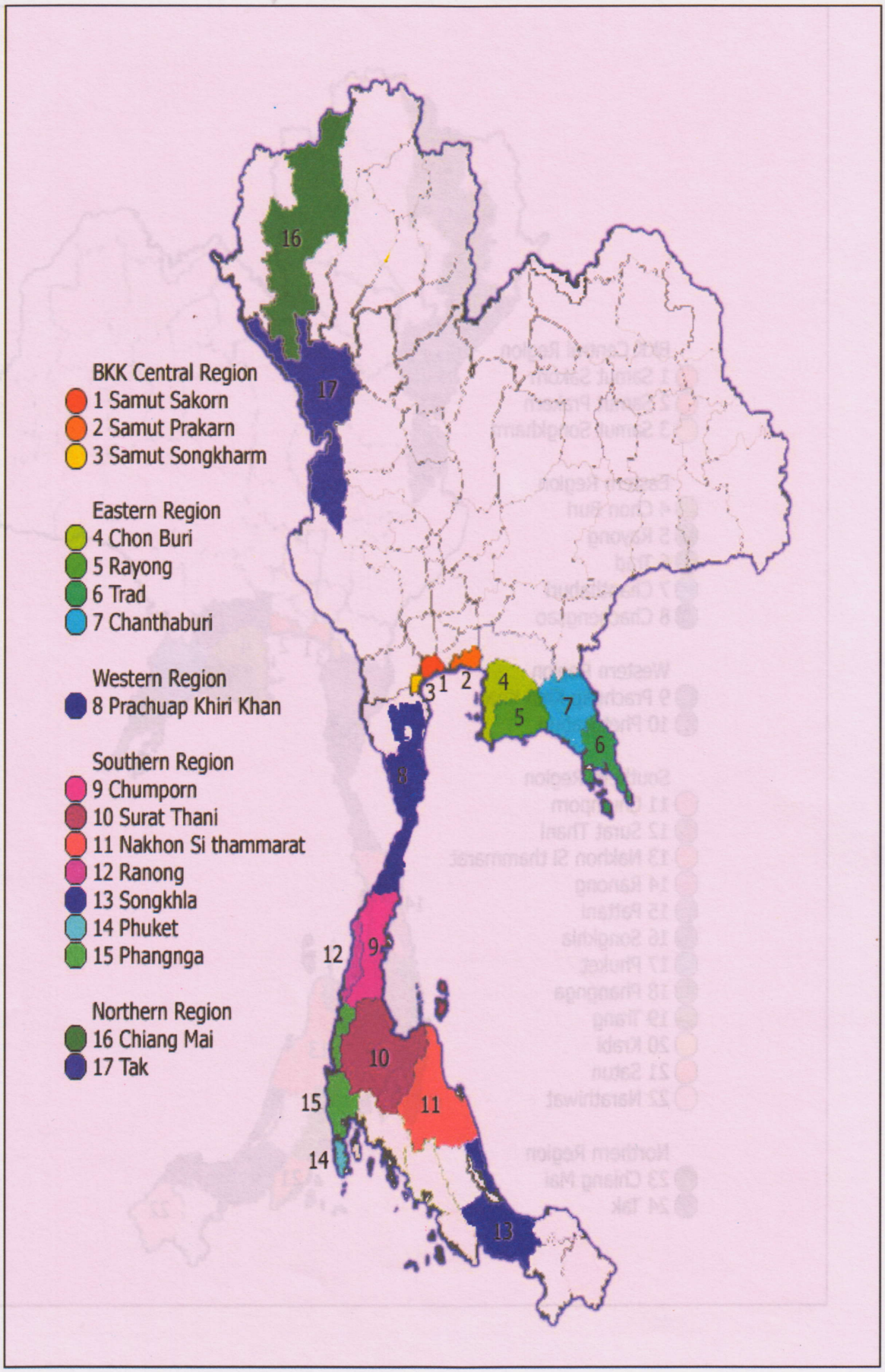
11 other respondents. The total number of seeds was calculated by dividing the target interview cases by 11. For the marine fisheries, male migrants age 15-49 were interviewed. For other occupational groups, the same age group of migrants was interviewed. Seeds were also identified by sex and detailed occupational groups (such as fishery-related work, labors, factory workers, household maids, and farm labors). It should be noted that the snowball cases did not have to be of the same sex and occupational groups as the seeds. The attempt to allocate seeds proportionally in different areas and by sex and occupational groups was done in order to maximize the spread of recruited respondents according to the actual settlement pattern and distribution of migrant workers in different work – related activities.

According to the above procedure, the overall sample size was estimated to be 3,537 from 17 provinces (see the following Table 3.1 and Figures 1 and 2). However, as presented in the Table, the number of interviews did not exactly match the plan. This was due to the changing settlement situation of migrants and the nature of the snowball technique. The only major and evident gap was found in Samut Sakorn and Samut Songkharm. More marine fisheries were interviewed in Samut Songkharm than in Samut Sakorn. And the opposite was true for fishery – related work. Another gap was the shortage of Laotian workers to be interviewed. This was due to the difficulty in identifying Laotians from Thais. In spite of the drawbacks of the sampling procedure, it was decided that the analysis would not employ a weighting scheme that adjusted for the gaps as the magnitude of the gaps in general is not crucial. The geography and nature of work in Samut Sakorn and Samut Songkharm, two connecting provinces, is also very similar. The population of the Laotian marine fisheries was also comparatively very small.

Table 3.1: Number of migrant workers planned to be interviewed and actually interviewed during April- June 2004, distributed by the 17 provinces selected for the baseline survey, and by nationality and occupational groups

Province	Survey sites		Burmese				Cambodian		Lao		Total
			Marine fisheries	Fishery-related work	Factory workers	others	Marine fisheries	Fishery-related work	Marine fisheries	Fishery-related work	
Samut Sakorn	Amphoe Mueang	Interviewed	157	247							405
		(planned)	(185)	(119)							(304)
Samut Songkharm	Amphoe Mueang	Interviewed	243	70							313
		(planned)	(185)	(119)							(304)
Ranong	Amphoe Mueang	Interviewed	193	117							310
		(planned)	(185)	(119)							(304)
Chon Buri	Amphoe Sattahip	Interviewed		120			102	52			274
		(planned)		(119)			(94)	(60)			(273)
Rayong	Amphoe Mueang, Amphoe Klaeng	Interviewed					60		4		64
		(planned)					(60)		(110)		(170)
Chanthaburi	Amphoe Tha Mai	Interviewed					98				98
		(planned)					(94)				(94)
Samut Prakarn	Amphoe Mueang, Amphoe Bang Bo, Amphoe Phra Pradang	Interviewed		92					3	44	139
		(planned)		(119)						(71)	(190)
Trad	Amphoe Khlong Yai	Interviewed					94	60			154
		(planned)					(94)	(60)			(154)
Chumporn	Amphoe Mueang, Amphoe Pathio	Interviewed	185	110							295
		(planned)	(185)	(119)							(304)
Surat Thani	Amphoe Don Sak, Amphoe Tha Chana	Interviewed		95							95
		(planned)		(119)							(119)
Nakhon Sithammarat	Amphoe Khamom	Interviewed	193								193
		(planned)	(185)								(185)
Phangnga	Amphoe Thai Mueang, Amphoe Khura Buri	Interviewed	192								192
		(planned)	(185)								(185)
Phuket	Amphoe Mueang, Amphoe Thalang	Interviewed		118							118
		(planned)		(119)							(119)
Prachuap Khiri Khan	Amphoe Mueang, Amphoe Pran Buri, Ampohe Bang Saphan	Interviewed	192								192
		(planned)	(185)								(185)
Songkhla	Amphoe Mueang	Interviewed	99								99
		(planned)	(185)								(185)
Chiang Mai	Amphoe Mueang Doi Saket, Hang Dong, San Kamphaeng	Interviewed	59	66							125
		(planned)	(66)	(47)							(113)
Tak	Amphoe Mae Sot	interviewed			111	249					360
		(planned)			(108)	(241)					(349)
Total		**interviewed**	**1454**	**969**	**170**	**315**	**354**	**112**	**8**	**44**	**3426**
Total		**(planned)**	**(1480)**	**(952)**	**(174)**	**(288)**	**(342)**	**(120)**	**(110)**	**(71)**	**(3537)**


BKK Central Region
1 Samut Sakorn
2 Samut Prakarn
3 Samut Songkharm
Eastern Region
4 Chon Buri
5 Rayong
6 Trad
7 Chanthaburi
8 Chachengsao
Western Region
9 Prachuap Khiri Khan
10 Phetchaburi
Southern Region
11 Chumporn
12 Surat Thani
13 Nakhon Si thammarat
14 Ranong
15 Pattani
16 Songkhla
17 Phuket
18 Phangnga
19 Trang
20 Krabi
21 Satun
22 Narathiwat
Northern Region
23 Chiang Mai
24 Tak


BKK Central Region
1 Samut Sakorn
2 Samut Prakarn
3 Samut Songkharm
Eastern Region
4 Chon Buri
5 Rayong
6 Trad
7 Chanthaburi
Western Region
8 Prachuap Khiri Khan
Southern Region
9 Chumporn
10 Surat Thani
11 Nakhon Si thammarat
12 Ranong
13 Songkhla
14 Phuket
15 Phangnga
Northern Region
16 Chiang Mai
17 Tak

3.3 Questionnaire design

In February and early March, 2004, the interview schedules for the Baseline Survey were developed. The core indicators, including key outcome indicators important to the PHAMIT project, were identified and incorporated into the interview schedules. The questionnaire was divided into seven sections. This included sections on background socio-demographic characteristics, knowledge of HIV and route of transmission, attitudes related to HIV/AIDS, sexuality, condom use, use of contraceptive methods, life skills, awareness of rights and responsibility and access to services.

Four versions of the questionnaire were developed (English, Thai, Burmese, and Cambodian). A pretest was conducted in late March, 2004 in Samut Sakhon.

3.4 Field survey

During the months of March and early April 2004 the recruitment of the field staff was undertaken. The interview teams were composed of one supervisor and 4 to 5 interviewers. Seven teams were established, each headed by OPTA personnel and with selected interviewers recruited from Burmese and Cambodian students and affiliated NGO staff. The training of interviewers and supervisors were conducted by the Office of Population Technical Assistance Team (OPTA) in April 2004.

The field survey was carried out from the second week of April to the end of June 2004. The completed interviews were 3,426 in total, compared to the target of 3,537. The completion rate was 96.9 percent. It should be noted that the original proposed target was 4,000 cases (400 cases x 10 provinces). This was later revised to stratify the samples by nationality and occupation, thus increasing the number of provinces to 17. Because of this increase in the geographic areas, the total number of interviews was reduced to about 3,500 in order not to exceed the original budget.

3.5 Data processing and analysis

Data editing, coding, and data entry were carried out from the end of June 2004 and was completed at the end of July. The creation of SPSS files and preliminary analysis, also including machine editing, was completed at the end of July. The analysis was carried out with the weighted total of migrants in all areas. Because of the priority of the implementation programs, the analysis focused on migrants from Myanmar and

Cambodia. The research team finished the analysis and the draft report during the period August-September 2004.

Chapter 4: General Characteristics of Migrant Workers

In this chapter, social, demographic and economic characteristics of migrant workers are described. These characteristics include the age and sex of migrants, their marital status, ethnicity and religion, and education. The focus of the description is on the work the migrants, including length of employment, whether they have work permit, and type of permit. Income and wage information are highlighted. The number of years that the migrants have lived in Thailand, and lived in the province of current residence, whether had moved in the last year, living arrangements and type of housing are also described. Also explored in order to address issues of integration into Thai society are whether the migrants have relatives in Thailand, and whether and how well they can speak Thai.

The tables (Table 4.1in Annex A) are presented for the two areas of residence, the 15 coastal provinces, and the two inland provinces of Chiang Mai and Tak. The country of origin is presented in separate columns, Myanmar and Cambodia. The weighted total for the two areas (the coastal provinces and the inland provinces) are also provided in the tables.

4.1 Age and sex distribution

The age distribution of migrants is consistent in all areas and for both nationalities of migrants. The mean age ranges from 25 to 28 (Table 4.1 in Annex A). Male migrants from Cambodia are the youngest, 25 years old on the average. The oldest migrants appear to be females (mean of 28 years old), of all nationalities and areas. Overall, migrants are generally young, the peak age groups being 20-24 years and 25-29 years respectively. There are less than 10 percent of all migrants that are at adolescent ages. Similarly, there are few older migrants (ages over 40), although in this age group there are more females than males. The concentration of migrants at young ages highlights the importance of the program targeting services to the young generation who are probably more sexually active and at risk in the HIV/AIDS epidemics.

Table 4.1 reveals distinct patterns between the coastal and the inland provinces. In the coastal provinces, there are many more male than female migrants, the sex ratios being as high as 500 among migrants from Myanmar and more than 1000 among the Cambodians. In contrast, in the two inland provinces, female migrants slightly outnumber male migrants.

This may be related to the different nature of work in the two areas, the fishery and seafarers in the coastal provinces and factory workers in the inland provinces. The occupation distribution of migrants, discussed below, helps clarify the difference in the sex ratios.

4.2 Marital status

Male migrants are typically single. This is true across all areas and nationalities of migrants. Marital status of migrant workers from Cambodia is very distinctive. Not only are 66 percent single, a high percentage (25 percent), are from broken marriage (separated/widowed/divorced). Cambodian male migrants who are currently married comprise less than 10 percent of male Cambodian migrants. Female migrant workers from Myanmar in the two areas, coastal provinces and inland provinces, are characterized by different marriage patterns. In the coastal provinces, female migrant workers are mostly married (about 70 percent). They probably follow their husbands who work as seafarers and fisherman. Because of the different line of work, female migrants in Chiang Mai and Tak are predominantly single (about 54 percent). Most of them can come on their own to work as factory workers. In summary, the diversity in marital status of migrant workers points to the importance of the implementation program design to target equally the migrant's sexual behaviour with both regular and non-regular partners. In addition, the extent of migrants frequenting sex workers probably need to be adequately incorporated into the HIV/AIDS prevention program design.

4.3 Ethnicity and religion

The ethnicity of migrant workers is related to the country of their origin. Almost all migrants from Cambodia are of Khmer ethnic origin (99 percent). The majority of migrants from Myanmar (up to 61 percent) are Burmese. In the coastal provinces, Mon accounts for about one-fourth of migrant workers. Karen are also presented in the coastal and inland provinces. In Chiang Mai and Tak, other minorities are also significant (almost 20 percent) and probably include migrants from Shan State.

Buddhism is the predominant religion for all nationalities and areas. Almost 100 percent of migrant workers in the coastal provinces are Buddhist. Almost 10 percent of Cambodian workers are, however, Muslim. Migrants in the North, i.e., Chiang Mai and Tak are more diverse in their religion. Although Buddhism is the majority religion of migrants (70 percent), Christianity and Muslim account for 23 and 7

percent respectively. Since almost one-third of migrants are Christian and Muslim, implementation program related to the sensitive issues of reproductive health and sexual behaviour need to be designed with careful consideration.

4.4 Education

Migrant workers vary in terms of their education level. The fishery workers in the coastal provinces tend to have lower education than the inland factory workers. On average, migrants from Myanmar and Cambodia who work in the fishery industry in the coastal provinces have about 5.2 years of schooling. Almost half of those from Myanmar have only 1 to 4 years of schooling. In contrast, migrants from Myanmar to the north of Thailand tend to be more educated, having about 7 years of schooling on average. For all groups of migrants, males have higher levels of educated than females. In general, the education of migrants is low, especially among those in the fishery industry and among women. The design of the implementation program has to take into account this disadvantageous position of women and fisherpersons.

4.5 Occupation

The most crucial characteristic of migrants is their occupation. Migrant workers in the coastal provinces have of course different occupation from those in the inland provinces in the North of Thailand (Table 4.1 in Annex A). The majority of migrants in the coastal provinces work in the fishery industry in contrast to those in Chieng Mai and Tak who mainly work in factories and in the market. For example, in the coastal provinces, men from Myanmar work mainly as seafarers (62 percent) and women work as fish processing labor (60 percent). This division of labor by sex is even more clear-cut among the Cambodian migrants. A large majority, that is, 78 percent, of Cambodian men are seafarers and 74 percent of Cambodian women work in fish processing activities.

4.6 Work permit

A large proportion of migrant workers do not have work permit and may be considered as illegal migrant workers. This is especially true for Cambodian migrants. Only about 20 percent (Table 4.1 in Annex A) have a work permit of any kind. Slightly more than half of migrant workers from Myanmar have a work permit. In Chiang Mai and Tak, female migrant workers are more likely to have a work permit than are men (61 percent compared to 49 percent). Among those who have a

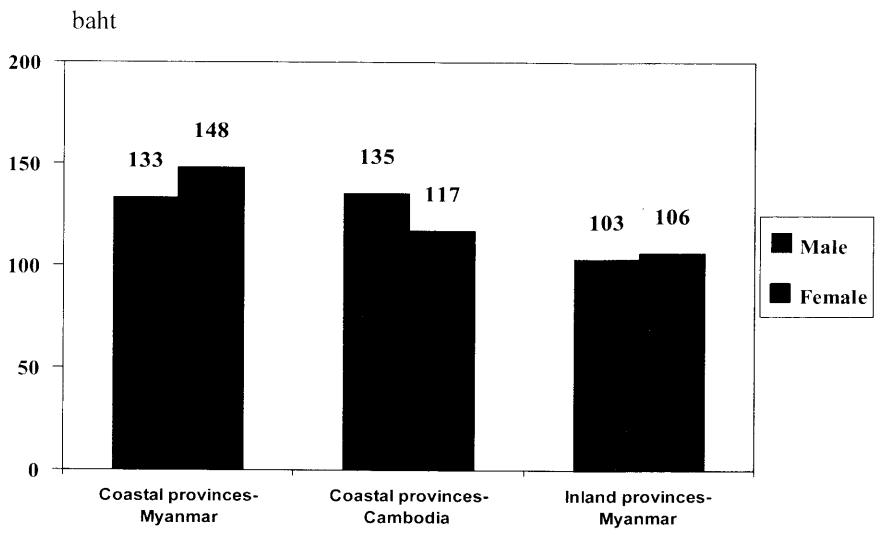
work permit, the majority of migrants from Myanmar (more than 70 percent) have a work permit card. Migrants from Cambodia, on the other hand, have a more restricted permit card. Most of them have only a blue or green card.

Unlike migrants from Myanmar, Cambodians have generally been employed for a shorter period of time. Almost one-third has been working in their current job for less than 6 months (Table 4.1 in Annex A). On the average, Cambodian migrants have worked for less than two years. In contrast, workers from Myanmar average three and a half years in their current work. More than one-fourth of migrants from Myanmar have worked in their current work for more than 5 years.

4.7 Income and wages

The average income of migrant workers is lower than the average of Thai labor in a similar situation. The daily wage of migrants range from 100 baht to no more than 150 baht per day depending on location. The fishing industry in the coastal provinces provides higher pay than the factory work and other work in the inland provinces. Surprisingly, Burmese women who work mainly on the fish processing activities along the coastal provinces earn the highest average wage, i.e., 148 baht per day (Table 4.1 in Annex A). The male seafarer groups also receive substantial pay, about 135 baht per day, equal for both nationalities. In contrast, both male and female inland factory worker average only slightly more than 100 baht per day. About 40 percent, earn less than 100 baht per day. Daily wage is also consistently higher among those who have work permit or can speak Thai.

Figure 4.1: Mean wage per day (baht).



Source: Table 4.1 (Annex A).

4.8 Duration of migration to Thailand and to the province of current residence

It is clear that labor migration from neighboring counties has been a continuing and consistent process for quite a period of time, especially as far as the stream of labor migration from Myanmar is concerned. During the past four years, migration from Myanmar has been consistent and probably increasing. On the average, migrants from Myanmar moved to Thailand about four and a half years. The long time settlers, or those who move to Thailand more than 5 years ago account for more than one-third of the migrant population. The issue of their integration into Thai society, or being provided Thai citizenship, is a delicate and challenging issue and would affect the design of the implementation program. The complications need to be addressed with all government and private sectors and local communities concerned.

Workers from Cambodia have generally moved more recently, than migrants from Myanmar, i.e., 2.3 years on the average. Migration of Cambodians is a more current phenomenon and has peaked only in the last six months. Implementation program will have to be responsive to the emerging and recent settlement and needs.

The difference in the number of years since migrants moved to Thailand and to the current province of residence indicate whether migrants have moved directly to the current provinces or had moved to somewhere else

before. The data in Table 4.1 in Annex A reveals that the difference is significant for migrants from Myanmar to the coastal provinces. On the average these migrants had moved to Thailand 4.5 years previously but had moved to their current province of residence only 3.6 years previously. The one year gap indicates that migrant workers from Myanmar probably moved from Myanmar to somewhere in Thailand first as a stepping stone before they moved again and settled down in the current coastal provinces of residence. The stepping stone process helps migrants to adjust themselves gradually before they work more long term in the their current provinces of residence.

This situation is not the case for the Cambodian and Burmese migrants to the inland provinces. For them there is little difference between the time they moved to Thailand and to their current province of residence. As observed previously, Cambodian migrants tend to be have recently moved to Thailand. They also move directly to their current province without any adjustment process. The adjustment to the current place of residence is probably more difficult for them. Migrant workers from Myanmar to the inland provinces of Chiang Mai and Tak generally move directly from Myanmar. In those areas the two countries have a land border and hence the adjustment is probably not as difficult. In fact, we do not know whether and how many migrants to these two provinces actually move out to other provinces. The extent to which these two provinces serve as stepping stones for migrants to move further is still unknown.

4.9 Move in the last year

Data on whether migrants had moved in the last year help support the conclusion that migrants from Myanmar to the coastal provinces are more dynamic than the other two streams. Almost ten percent of these migrants had moved in the past year. The figures for the other two streams of migration are, in contrast, almost negligible. Again the program design should take into consideration the dynamic nature and mobile activities of seafarers from Myanmar.

4.10 Migrants' living arrangement and type of house

The majority of the Cambodian migrant men, mostly the seafarers, live with their employers, i.e., as many as 72 percent, and live mainly in boats, i.e., 62 percent (Table 4.1 in Annex A). Cambodian women they tend to live with their husband and in a rented house. Some of them live with their employer and stay in a dormitory at the workplace. Most male

migrants from Myanmar in the coastal provinces live with friends and stay in a dormitory at the workplace, rented room or apartment or in boat where they work. The majority of women live with their spouse and reside in a dormitory at the workplace or a rented room. Migrant workers in the two inland provinces, both men and women, primarily live with their spouses or friends depending on their marital status. Although the type of houses they live in varies, the majority stay in a dormitory at their workplace.

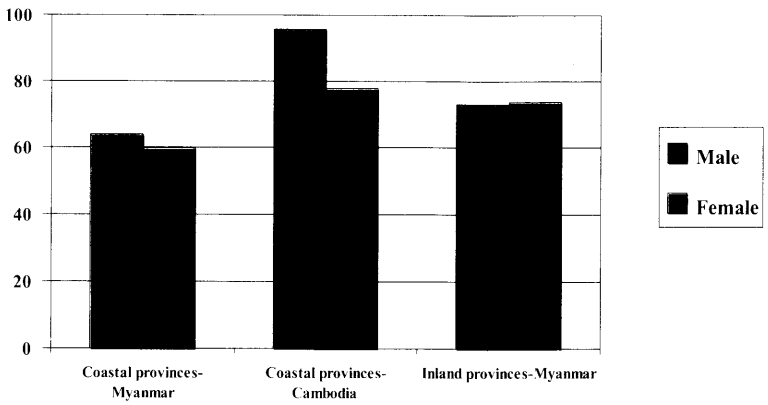
4.11 Assimilation to the community in Thailand

To gauge the extent to which migrant workers are assimilated into the Thai community, information on whether migrants have relatives in Thailand and whether and how well they can speak Thai was collected. Since networking plays a key role in inducing migration, it is not surprising that a large proportion of migrant workers have relatives in Thailand. Migrants from Myanmar to the coastal areas are the most likely to have relatives in Thailand (57 percent). In contrast, only 37 percent of Cambodian migrants have relatives in Thailand. It is not unexpected that women, being generally more risk adverse, have more dense networks in Thailand than their male counterparts. Data for all streams of migration show clearly that more female than male migrants have their relatives in Thailand.

The data reveal that the majority of migrants of all three streams can speak Thai. This is probably not surprising considering the length of stay in Thailand and the duration of their work. However, among those who can speak Thai, migrants from Myanmar are likely to be able to speak more fluently than the Cambodian. Again, as discussed earlier, Cambodian migrants are relatively newcomers compared to their counterparts from Myanmar. In general, the data suggest an optimistic view of the future assimilation of migrants into the Thai community. However, since a large number of migrants are illegal, although they have worked and stayed in Thailand for a long time, the contradicting policy issue of assimilation and becoming Thai citizen is very sensitive. Whatever happens, the design of the implementation program has to take into account all of these challenges.

More comprehensive knowledge of HIV/AIDS is further explored among these groups of migrants. Table 5.1 presents knowledge about the different routes of transmission of AIDS namely: sexual transmission, injections with a needle, blood transfusion, mother to child by birth, and mother to child by breast feeding. There is a high level of knowledge in all of these aspects. This probably reflects migrants' past exposure to prevention programs. However, knowledge is lower among female migrants from Myanmar who work in coastal provinces. This group should be an added target of the new intervention program.

Figure 5.2:Knowledge of prevention of HIV/AIDS.



More in-depth knowledge of HIV/AIDS among migrants was also explored. Focusing on misconceptions of the transmission of AIDS, questions were asked on whether one can get infected by sharing a meal with an HIV person or by a mosquito bite. Many migrants still hold these misconceptions. Up to about 40 to 50 percent of most of the groups still think that a mosquito bite can spread the infection. Again, the most critical groups are those from Myanmar, again suggesting that Cambodian probably have been previously exposed to prevention programs.

Respondents were also asked whether a healthy-looking persons can transmit HIV/AIDS, whether one can get HIV/AIDS through sexual contact, whether one can protect themselves from HIV/AIDS by abstaining from sexual intercourse, whether one can protect against HIV/AIDS by having only one uninfected sexual partner, and whether at present there is medicine to cure AIDS. Again, as the data show clearly,

although migrants have some knowledge on HIV/AIDS, a deeper understanding of the transmission, protection and cure of AIDS is still not complete.

Knowledge on specific places where migrants can obtain a HIV test was investigated. Overall, knowledge of testing centers was far from being complete. However, migrants from Myanmar who work in Chiang Mai and Tak had the highest knowledge of the location of testing centers. This is probably due to the greater availability of health services in the area, specifically those made available for migrants. However, only about half of respondents believe that the test results would be kept confidential. The lack of trust in confidentiality of testing obstructs the HIV prevention program as a whole. Capacity and guidelines to enhance confidentiality need to be developed and strengthened.

Migrants from Cambodia who, as discussed earlier in Chapter 4, have been in Thailand for shorter periods than migrants from Myanmar, know much less about the places for HIV testing in their areas. This again supports the view their knowledge of HIV/AIDS must be from exposure to information in their own country, rather than from the current health service delivery points in Thailand. Similar to migrant workers from Myanmar, their trust in HIV testing confidentiality is low. Parallel programs are needed to ensure the success of any subsequent HIV prevention campaign and intervention.

5.2 Self perception of risk of HIV infection

Among migrants from Myanmar who work in the coastal provinces, about 10 percent of men state that they have some risk of HIV infection, and of these a third (3 percent overall) feel that they have a high risk of infection. More remarkably, almost 6 percent of women in the same areas feel that they have high risk of infection. Similar figures are found for the Cambodians in the coastal areas. About 10 percent report a possible risk of HIV infection. These figures are truly alarming and call for timely action.

Comparable evidence in Chiang Mai and Tak is not as worrying, probably due to the different line of work and way of life. Work in these areas is perhaps less stressful and migrants may stay closer to the family. In addition, the greater availability and establishment of health information and services in the areas may explain the difference. However, evidence shows that women in these areas feel more at risk of infection than do men. Male migrants are more capable of protecting

themselves. Women, on the other hand, are at risk probably because they have no bargaining power with their partners on safe sex and cannot know or control the sexual activities of their partners.

The above speculation is supported by the reasons behind the self-perception of risk of men and women under investigation. Most men reported that they have risk because they have sex with sex workers. More women than men stated that they are at risk because they cannot trust their partners.

Male migrants who perceive themselves as having no risk stated that they do not visit sex workers, they use condoms, or they have partners they can trust. For women, apart from not having sexual intercourse or having only one monogamous partner, many reported that they are not at risk because they do not have HIV infected friends, or that they or their partners do not visit sex workers. Although women appear to be not as much risk as men, women's perception seems to be more of wishful thinking than their male counterparts. Women rely on trust of themselves and of their partners more than condoms. They may be more vulnerable and may need more help from than men.

Lastly, it should also be noted that there are 10 to 20 percent of migrants who could not say whether they were at risk or not. This group of migrants may be the most vulnerable. Migrants who know that they are at risk may learn about, and practice, safe sex. But those who do not even know their risk, and some of those who think that they are not at risk, may not be in the position to protect themselves and therefore may be in danger.

5.3 Knowledge, perceptions and attitudes on condom

The majority of migrants, especially men, have heard about or seen a condom. Figure 5.3 illustrates the almost universal knowledge of condoms among Cambodian men and very high levels of knowledge among Cambodian women. The comparable figures among migrants from Myanmar are lower. This is especially true among female migrants from Myanmar who work in the coastal provinces. Only one-half had heard about or seen a condom. Programs to increase woman's participation in safe sex may have to start from the very beginning, i.e., introducing the condom to them.

Figure 5.3: Knowledge of condom.

Source: Table 5.2 Annex A.

For those who know about condom, the purpose of condom was asked. The majority of migrants cite AIDS prevention as the purpose of condom use (Table 5.3 in Annex A). This is especially true for the Cambodians (91 percent), who also mention STIs prevention (62 percent). Unlike the Cambodians, STIs prevention is cited as the purpose of condom use, much less commonly among female migrants from Myanmar. In contrast, using condoms to avoid pregnancy is stated more among migrants from Myanmar than those from Cambodia.

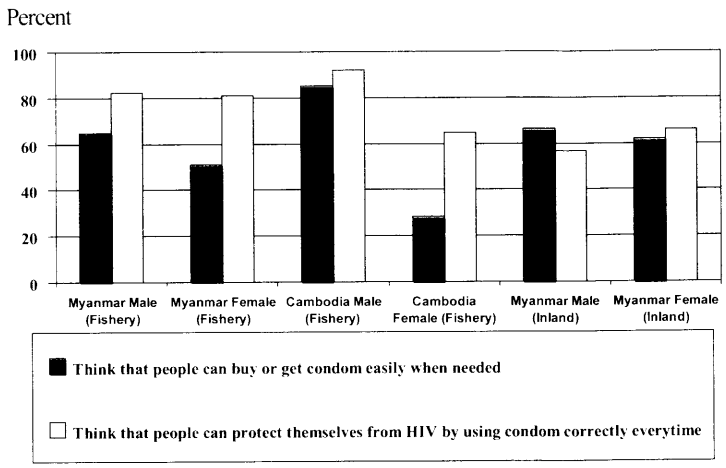
Because of the mass media and public awareness campaigns, it is not surprising that people have more knowledge, and are even are more conscious, about AIDS than STIs. Condom use is therefore viewed more in relation to AIDS than STIs. It is also critical to observe that as condom use for AIDS prevention becomes more popular, such as in the case of the Cambodians, the use of condom for contraceptive purpose could also become less common. The campaign to advocate the acceptability of condom should be designed to be dynamic enough to promote its use to avoid pregnancy as well as to protect oneself from AIDS and sexually transmitted infectious diseases.

Knowledge of sources of condoms is presented in Table 5.4 in Annex A. Sources of condom can be individuals or places belonging to the government, NGOs or private sector. More than one-half of migrants from Myanmar know that they can obtain condoms from health centers, government STI clinic, government hospitals, and private clinics and hospitals. In contrast, a much lower proportion of Cambodian migrants

Although migrants may know about condoms and the places where they can get them, they may not be able to easily obtain condoms, or they might not know that using condoms correctly every time can protect themselves and their partners from HIV/AIDS. Migrants were therefore asked whether in their opinion, for those who needed to obtain a condom, whether condoms were easily available, and whether people can protect themselves from HIV/AIDS by using condom a correctly every time they have sex. To explore whether there was a difference between men and women in their access to condom, respondents were asked whether they agreed that only men can get condoms.

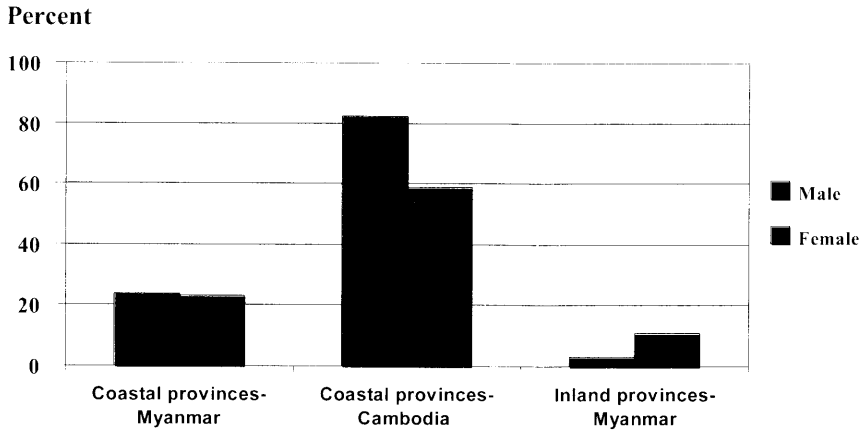
Figure 5.4 presents migrants' perceptions on the accessibility of condoms, and their beliefs about whether HIV/AIDS can be prevented by the consistent and correct use of condoms. Overall, the majority of migrant workers believe that condoms are easily accessible to people who need to have one. This is especially true for the Cambodians. Men also perceive greater accessibility of condoms than do women.

Figure 5.4: Perspectives on the accessibility and correct application of condom.



Perception of gender difference in access to condoms is presented in Figure 5.5. There appears to be a large contrast in the perceptions of migrants from Myanmar and from Cambodia. The large majority of the Cambodians, especially men (82 percent), agree that only men can get condoms. On the contrary, 76 and 94 percent of migrants from Myanmar in the coastal and inland provinces respectively, disagree that only men can get condoms. This encouraging situation for Myanmar migrants probably is due to the existing programs that focus on making condoms available to both men and women.

Figure 5.5: Perception on gender difference in the access to condoms.



Percent agreed that only men can have condoms.

5.4 Knowledge, prevalence and treatment of STIs

The condom use campaign against HIV/AIDS would benefit a great deal with a parallel or built-in program to concurrently promote the prevention of sexually transmission infections (STIs). In this section the knowledge of STIs and STIs symptoms among migrant workers is explored. The self reports of infection and treatment of STI symptoms are investigated. Lastly, migrants' preferences for places where they could obtain treatment for STI symptoms are described.

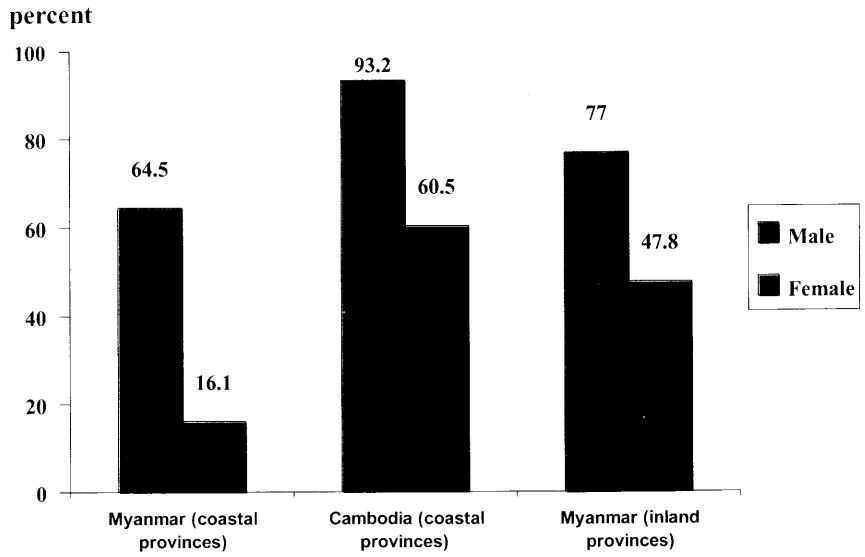
As in previous sections, results are tabulated from in Table 5.6 onward (in Annex A), and information is shown separately for the 15 coastal provinces and the two inland provinces of Chiang Mai and Tak, and for Myanmar and Cambodian nationality. The weighted total for the two areas are provided in the Table. Since the prevalence of STIs is low and cases with STIs symptoms are few in number, the analysis focuses on the total weighted cases. In this section, therefore, analysis and interpretation by nationality and by areas may not be possible for all issues.

Table 5.6 in Annex A shows broad knowledge of STIs among the majority of male migrants. This is especially true for the Cambodians. As high as 93 percent of Cambodian men and 61 percent of Cambodian women have ever heard of infectious diseases other than HIV/AIDS that can be transmitted though sexual contact. The knowledge of the Cambodians is probably a result of them having been exposed to previous campaign in Cambodia. Migrants from Myanmar, especially women, are

much less likely to know about STIs. Only 16 percent of female migrants from Myanmar who work in the coastal provinces know of STIs. Since infection with an STI increases the chance of HIV infection, women from Myanmar need to be targeted with STI information.

Among those who know of STIs, not all are aware that the infection can increase the chance of contracting HIV. About 20 to 25 percent either do not think that persons suffering from STIs will have a higher probability of infection of HIV, or are not aware of the linkage at all. Campaigns on HIV/AIDS prevention should be made in parallel with the program to increase knowledge of STIs.

Figure 5.6: Knowledge of STIs.



Source: Table 6.1 (Annex A).

For those who were aware of STIs, more detailed questions on STI symptoms were asked. Knowledge of symptoms for both women and men infected with STIs is widespread, but certainly not universal. Women are slightly more likely to know about the symptoms of infected women than the symptoms for infected men, and vice versa. Both women's and men's symptoms which are cited correctly and relatively commonly include genital discharge, genital ulcers and sores, burning pain during urination, and skin rashes. Knowledge of the symptoms of men who are infected is generally more substantial and varies to a slightly greater extent than knowledge on the symptoms of infected women.

A question was asked whether the respondent had experienced a thick yellowish/greenish discharge with foul smell from their penis/vagina in the past 12 months. This indicator is meant to proximate the prevalence of STIs in the population under study during the past year. Table 5.7 (Annex A) shows that self reported rates varied from about 1 to 3 percent in the populations investigated. The total weighted self reported prevalence rate is shown 2.3. The male level is higher than that of the females among migrants from Myanmar, but the opposite is true among Cambodian migrants. It should also to noted that male migrants from Myanmar in the coastal provinces, the majority of whom are seafarers are characterized by the highest rate of 3.1 percent.

Table 5.8 (Annex A) presents the symptoms and treatment of this self-reported STIs infection among migrants. Since the number of female infected cases are so small, analysis was undertaken only among male migrants, and especially for the male seafarer group from Myanmar. About one-third of migrants with self-reported STIs, report that they had an ulcer or sore in their genital area. Migrants from Myanmar in the coastal provinces sought appropriate treatment for their STIs, with 70 percent purchasing medicine from a drug store and a small proportion visiting private or government clinic or hospital. No migrants reporting symptoms failed to seek treatment.

Lastly, Table 5.9 (Annex A) illustrates migrants' preference for places for treatment of STIs in a situation where they had a STI symptom. The majority of migrants, ranging from about 55 to 75 percent, would prefer to have treatment at a government hospital. The other preferred places among migrants from Myanmar are private hospitals, health volunteer/workers, health centers and private clinics. Although migrant workers from Cambodia would mostly go to government hospitals, some men (10 percent) would still prefer to see traditional doctors. However, as a whole, it is encouraging to note that migrants have good knowledge of treatment and prefer to approach appropriate places for STI treatment.

Chapter 6: Sexual Behaviour of Migrant Workers and Their Condom Usage

According to a public health point of view, the practice of safe sex is the most important element in the control of the spread of sexually transmitted diseases. Consistent with the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the Global Fund To Fight AIDS, Tuberculosis and Malaria(GFATM) and the Millennium Development Goals (MDGs), the central concern converges on condom usage. In tackling the complexity of changing human's sexual behaviour, the extent of condom use among migrant workers with their partners of different type is the most crucial indicator of program outcomes and success.

In this chapter, we will first explore the sexual behaviour of migrants. These include experience of sexual intercourse, age at first sexual intercourse, current partners by types of partners, including regular, non-regular and sex worker partners. The analysis also takes into account usage, and consistency of usage, of condom with these partners, usage of condom in the last sexual intercourse with partners, and reasons of non-use. Availability and accessibility of condoms is measured by sources of condom, access in terms of time used to get condoms and the consistency of this access. Factors related to failure to use condoms are also investigated. Important attributes such as the consumption of alcohol and drug use before sexual intercourse, preference and non-preference of using condom, and the negotiation process of using condom with partners are examined.

The tabulation of the results is presented in Tables 6.1 to 6.16 (Annex A). Information on migrants is presented according to the two geographic zones of residence or migrants, which are the 15 coastal provinces and the two inland provinces of Chiang Mai and Tak. The nationality of migrants is also used to stratify the results, with migrants from Myanmar and Cambodia differentiated. The weighted total for the two are also shown in the tables.

6.1 Experience of sexual intercourse

Table 6.1 (Annex A) reveals the proportion of migrants who are sexually experienced. The tabulation is undertaken separately by the marital status of migrants. In general, with the exception of female migrants in Chiang Mai and Tak, more than half of migrant workers have sexual experience

at the time of the survey. Even among the single persons (see table 6.2), many migrants of all nationality, especially men, have ever had sexual intercourse, (ranging from about 39 to 51 percent). For single women, however, the levels of sexual experience are low (about 4 percent). It is important to note that the intervention program needs to address all migrants, especially males, regardless of their marital status.

6.2 Age at first sexual intercourse

On the average, as shown in Table 6.1, ages at first sexual intercourse are relatively late, around 20 to 21 years across all the nationalities and all provinces under investigation. However, about one-third to almost half of migrants had their first sexual intercourse during their adolescent ages of 15-19. In the coastal provinces, it is surprising to observe that more women than men had first engaged in sexual intercourse during these ages. One reason is that these women may marry younger than do men. Whether the sexual intercourse occurs within or outside of their marriage, it is important to address their understanding of protection against HIV/AIDS, and the life skills to implement protection strategies, at an early among these young and probably inexperienced women, and also their partners, in order to promote the practice of safe sex.

6.3 Current partners by type of partner: regular, non-regular, and sex worker

Among those migrants who ever had sexual intercourse, information is provided on the different types of sexual partners they are involved with. This information can be used to design or revise the implementation program. The types of partners are categorized as regular and non-regular sexual partners, with some overlapping features with non-regular partners, and sex workers.

6.3.1 Regular partner

Table 6.3 (Annex A) shows the extent that migrants (who ever have sexual experience) have regular partners. It is found that a large majority of them have a regular partner. This is especially true for women. For example, up to 92 percent of female migrants from Myanmar working in the coastal provinces, are living with their regular partner.

However, less than ten percent of these migrants, both men and women, and their partners ever use condoms. The lowest level of ever-use of condoms is found among migrants from Myanmar working in the coastal

provinces. Migrants in the inland provinces are characterized by the highest rate of ever use of condoms, but only about 9 percent.

The main reason of ever-use of condom with regular partners is for contraceptive purposes, that is, to avoid pregnancy. The intention to protect themselves from STI/HIV/AIDS accounts for about 20 to 30 percent of use among migrants from Myanmar. This level is much higher among the Cambodians, although the number of observation is small and should be interpreted with caution. It is also interesting to note that there are some migrants who report that they use condoms with their sexual partners in order to protect their unborn child from STI/HIV/AIDS. Although these are a small number of such cases, some of these respondents may be HIV positive, and special attention should be paid to them.

The majority of migrants who have never used condom with their regular partners explain that it is not necessary for them to do so. The Cambodians rely on trust of the partner the most (more than 80 percent). It should be noted also that, according to migrants' answers to all the specific questions, the factors underlying non-use or under-use of condoms with regular partners have almost nothing to do with condom availability, cost, objections made by partners, or any personal distaste. Therefore programs to promote condom use among regular partners need to conduct an in-depth analysis of the factors associated with trust, especially that given by women to their partners. The program needs to first review and uncover the reality about the faithfulness between partners, and to turn to the investigation of whether it is safe to rely on this love and trust. If this is not the case, more rigorous and intensive family-based implementation programs have to be designed.

6.3.2 Non-regular partner

Among migrants who ever have sexual intercourse, the extent that they had sexual intercourse non-regular partners in the previous 12 months is shown in Table 6.4 (Annex A). A much higher proportion of men than women have non-regular partners. Female migrants from Myanmar very rarely report non-regular partners (less than one percent). This is also similar for Cambodian women (less than four percent). For men, the Cambodians are the most likely to have had non-regular partners in the past 12 months (52 percent). Male migrants from Myanmar who work in the coastal areas are characterized by the second highest percent having non-regular partners (27 percent). Only 11 percent of migrant workers

from Myanmar living in Chiang Mai and Tak reported sexual intercourse with non-regular partners in the past 12 months.

The analysis by marital status reveals that single men are much more likely (almost double) to have non-regular partners than are married men. It is of great concern that for example, Cambodian single men are so sexually active, with 75 percent of them reporting that they had non-regular sexual partners in the 12 months before the survey.

Among those who had sexual intercourse with non-regular partners in the past 12 months, the number of non-regular partners was asked. On average, migrants had about 4.43 non-regular partners in the last year. This figure can is considered very high and points to the urgency of program interventions.

Table 6.5 (Annex A) shows that almost all male migrants in the coastal areas report that sex workers were one type of non-regular partner, with 97 percent of Cambodian men and 83 percent of migrants from Myanmar who work in the coastal provinces reporting that their non-regular partners included sex workers. For the former group, 11 percent mentioned their fiancé and girl friends as non-regular partners. For the latter group, about 20 percent revealed that they had girl friends as non-regular sexual partners. In these two groups the total percent of non-regular partners sums to more than 100 percent, indicating partners of different types for many men. In this regard, the spread of infectious diseases from sex workers to girl friends and fiancé is probably of greatest concern among intervention program implementers.

For male migrants from Myanmar in the inland provinces of Chiang Mai and Tak, girl friends are reported more often as non-regular partners than are sex workers (55 compared to 45 percent respectively). The potential for cross infection may be rare if the two partners are of different groups of migrants. However, the number of cases under observation in Chiang Mai and Tak may be too small to make generalizations.

As discussed earlier, the extent of having non-regular partners is almost negligible for women.

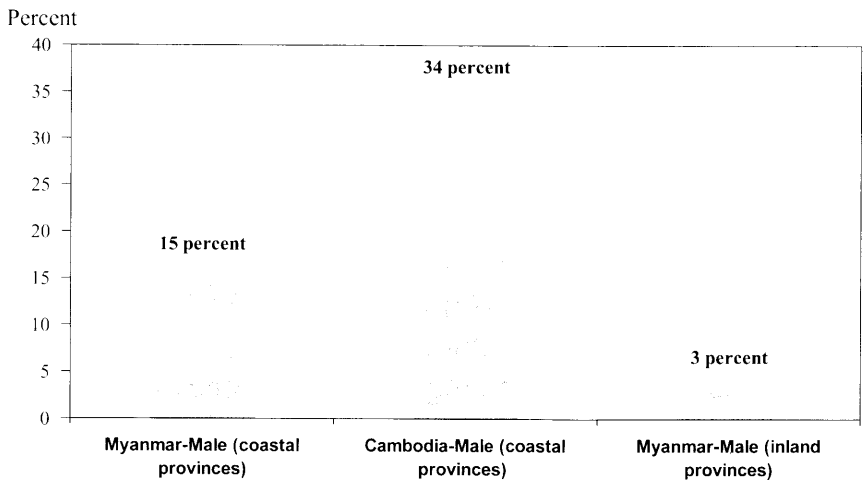
6.3.3 Sex worker

Data on migrants who ever has sexual experience with sex workers is shown in Table 6.5 (Annex A). The data show that the episodes of intercourse with male sex workers are negligible. The focus here is therefore on sex with female sex workers. For male migrants from Myanmar who work in the coastal provinces, out of the 27 percent of

them who have non-regular partners in the past 12 months, the majority of them (83 percent) report having sex with a female sex worker. Therefore about 22 percent of the group of sexually active migrants visited female sex workers in the past year. The comparable figure for migrants from Myanmar who worked in the inland provinces is only about five percent. The highest level is among Cambodian migrants in the coastal provinces. As many as half of men who were sexually active, had female sex workers as partners in the previous year.

In order to illustrate the overall extent of sexual intercourse with sex workers among male migrants, the data are presented in a graphic form below in Figure 6.1. Taking into account all men aged 15-49, regardless of their marital status and whether they ever have had sexual intercourse, 15 percent, 34 percent and 3 percent of male migrants from Myanmar working in the coastal provinces, all male migrants from Cambodia working in the coastal provinces, and all male migrants from Myanmar working in the inland provinces, respectively, had sex workers as non-regular partners in the past year. This shows the need to target male seafarers and related workers, especially Cambodians.

Figure 6.1: Percent of Male Migrants Aged 15-49 who had Female Sex Workers as Non-Regular Partners in the Past 12 months.



Source: Calculated from Tables 6.1, 6.4 and 6.5 (Annex A).

6.4 Consistency of use of condom in the last 12 months among male migrants with regular, non-regular partners and sex workers

Sexually active migrants who had regular and non-regular partners, as well as those who had sex workers as partners, were asked about their use

of condoms in the past year. Data are compared on the consistency of condom use among male migrants with their regular and non-regular partners and sex workers (Table 6.6, Annex A). The data are presented by the two nationalities. Because of the small number of cases, the two areas -- coastal and inland provinces -- are not separated. The weighted data are analyzed.

As discussed earlier, condom use is rare (under five percent) among male migrants and their regular partner, the consistency of condom use in this respect is also at a modest level. The majority use condoms only sometimes (74 percent). Those who always use condoms are very rare. Only a small minority (14 percent) use condoms most of the times with their regular partners.

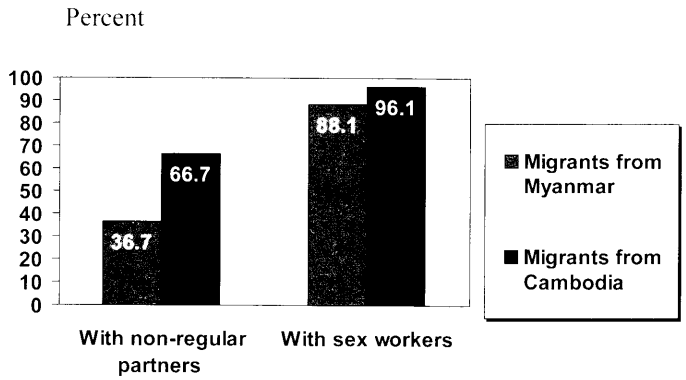
Consistency of condom use varies more when it comes to non-regular partners. Some male migrants always use condoms with their non-regular partners; 21 percent among the Burmese and 60 percent among the Cambodians. At the same time a large proportion never used condom with their non-regular partners in the last 12 months (53 percent among the Burmese, and 20 percent among the Cambodians). Others appear to have no fixed pattern in their consistency of condom use. Their non-regular partners, who are mostly "girl friends", probably have no stereotypical character, which implies a variety of types and behavior. The decision to use a condom with non-regular partners is complicated by types of partners. The program on condom campaign needs to take this sensitive issue and the dynamism of sexual behavior into account in their interventions.

Both Burmese and Cambodian migrants tend to use condoms to the highest extent when their partner is a sex worker (73 and 88 percent among the Burmese and the Cambodian respectively). However, a minority of male migrants never use a condom, or use only sometimes, when having sex with a sex worker. Although the consistency of condom use is high among the majority of migrants, the aim to prevent infection is to have 100 percent consistent use. It is still very important to close this gap with vigorous and concentrated programs with sex workers and their clients.

Another way to measure the consistency of condom usage is to examine the extent of condom use at the time of last sexual intercourse. These data are also presented in Table 6.6. It is confirmed that condom use is

not at the level of 100 percent practice. Secondly, the level of use depends on the type of sexual partner, with the level of condom use is highest with sex workers. It should be noted that Cambodian migrants are probably slightly more cautious than are the Burmese. The use of condoms among the Cambodian migrants at last sexual intercourse with sex workers is almost universal (96 percent). For the Burmese, 11 percent did not use a condom at last sexual intercourse with a sex worker. This figure may be considered to be high (Figure 6.2).

Figure 6.2: Use of condom at the last sexual intercourse with non-regular partners and sex workers.



Source: Table 6.6, Annex A

Although number of cases is small, in Table 6.7 (Annex A) displays the reasons for not using a condom with non-regular partners for male migrants from Myanmar. Thee majority think that it is not necessary (54 percent). Almost 20 percent reported that they do not like condoms. Thirteen percent did not think of it and almost ten percent say condoms were not available. The cost of condom is not cited as a reason for non-use. The program design for promoting use should take all of these different aspects into account, and aim to increase awareness and provide knowledge, change attitudes, make condoms available, and perhaps improve condoms to meet the preferences of users. Multidimensional programs are needed.

As for the condom use with sex workers, similar patterns are revealed. However, the idea that condom is not necessary is less often provided than in the case of a sexual relationship with other non-regular partners such as girl friends. Distaste of condom use is cited the most often. In

contrast to non-regular partners, the cost of condoms is also a factor for non-use of condoms with sex workers. Lastly, objection from partners accounts for about 13 percent of reasons for non-use. This is probably due to discomfort and long duration of sexual intercourse experienced by sex workers with some customers who use condoms. In summary, the program aimed at sex workers also needs a multi-dimensional approach to address the needs of both sex workers and the clients.

6.5 Accessibility of condoms

Accessibility of condom is investigated in three aspects. First, sources of condoms as reported by migrants who use them with regular partners, non-regular partners and sex workers is explored. Secondly, the access to condoms is measured by time used to get a condom as reported by users of condom with the three types of partners. Thirdly, the consistency of being able to obtain a condom every time it is needed is examined among migrants who have sexual relationships with regular partners, non-regular partners and sex workers.

6.5.1 Sources of condom

Table 6.8 (Annex A) shows that a large proportion of migrants who use condoms with their regular partners obtained them from a drugstore (42 percent). Grocery store, health center and volunteer health workers, are also sources of condom, although they are not very popular. It is interesting to note that as high as about one-fourth of migrants acquired condoms from a peer educator/NGO.

For use with non-regular partners, about half of migrants said that they do not have to buy condoms. The remainder obtained their condoms from drugstores or grocery stores or shops. In contrast, male migrants who visited sex workers, mainly obtained condoms from the entertainment venues such as brothels or bars (more than 50 percent). Other places are not major sources of condoms. The program for geographically concentrated groups such as sex workers and clients would be most economical if it focused on the entertainment workplace.

6.5.2 Time used to get access to condom

Users of condom with the three types of partners reported the time taken to obtain condoms. Data are presented in Table 6.9 (Annex A). It is interesting to see that the time used varies by the types of partner. It took

longest to obtain a condom for use with regular partners, i.e., 33 minutes. With non-regular partners, it took less than 20 minutes on average to obtain a condom. Male migrants can get a condom in the shortest time (within 6 minutes) when having sex with sex workers. They probably obtain the condom in the entertainment workplace, bar or brothel. Again, this suggests the higher efficiency of implementation program focused on concentrated target groups such as the sex workers, as compared to the more difficult task of addressing the general population, at the household level or at adolescent groups on the street.

6.5.3 Consistency of access to condoms

A question was asked to users of condom who used it with different types of partners about whether they could obtain a condom every time they needed one. Table 6.10 (Annex A) presents the responses of migrants who are condom users by type of partners. It is encouraging to find that among these men who are actual users of condom the majority of them, ranging from 82 to 97 percent, report that they can obtain a condom every time they need one. This is especially so for use with sex workers. Almost 99 percent of Cambodian men said that they could obtain condoms every time when they have a sexual relationship with sex workers. A similarly high figure (97 percent) applies for male migrants from Myanmar working in the coastal provinces. The availability of condoms is therefore probably not a problem. The use of condoms may be more related to attitudes and preferences, which need to changed through approach behavioural change programs.

6.6 Factors related to failure to use condom

As levels of condom use vary among different partners, as shown above, the factors underlying the failure to use condom are of great interest. In their section several factors will be investigated, including consumption of alcohol and drugs before sexual intercourse, personal preferences or distaste of using condoms, and negotiation skills and the process of using condoms with partners.

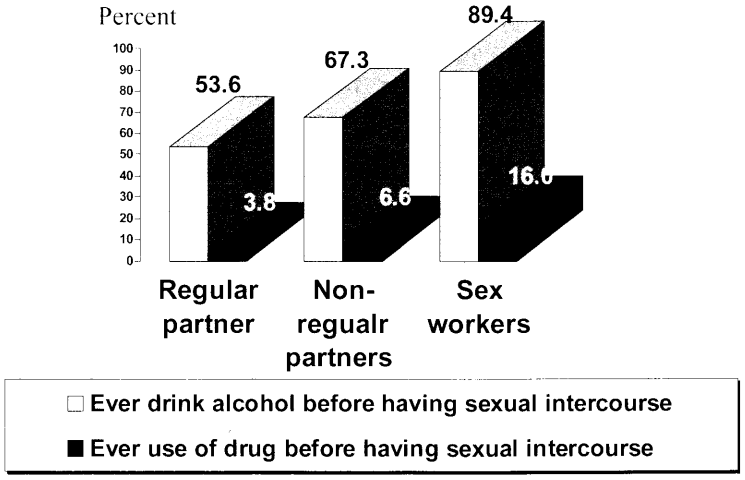
6.6.1 Consumption of alcohol and drug use before sexual intercourse

Table 6.11 (Annex A) reveals that the use of alcohol and drugs before intercourse is lowest in sexual relations with regular partners. The level increases with non-regular partners and is highest before sexual relations with sex workers. With regular partners, the use of drugs occurs in less

than 5 percent of relationships and the majority use drug only sometimes. With non-regular partners, the level of use is higher, almost 10 percent among male migrants from Myanmar in the coastal provinces. It is alarming to note that among male migrant workers who visit sex workers, the proportion using drugs before sexual intercourse is as high as one-fourth among migrants from Myanmar living in the coastal areas. More than 20 percent of this group use drug either always or most of the time. This finding calls for an even more vigorous program of condom promotion that take into consideration such contextual factors when applying models of behavioural change.

The consumption of alcohol before sexual intercourse with different types of partners is also presented in Table 6.12 (Annex A). It can be seen that drinking alcohol before sex is quite common among migrants. The consumption of alcohol before sexual intercourse with three different types of partners has the similar pattern to the use of drugs discussed above. The consumption of alcohol increases from 40 percent among migrants having sex with regular partners to 68 percent among those with non-regular partners, to as high as 98 percent with sex workers. The figures for males are presented in Figure 6.3.

Figure 6.3: Use of alcohol and drugs by male migrants before having sexual intercourse with regular partners, non-regular partners and sex workers.



Source: Tables 6.11 and 6.12, Annex A

The frequency of drinking also increases with type of partner. Before having sexual intercourse with sexual workers, most male migrants would

drink alcohol and the majority of them would do it either always (21 percent) or most of the time (30 percent). Again, as discussed earlier relating to drug use, alcohol consumption before sexual intercourse makes condom promotion more complicated, and probably expensive, but needs to be taken into consideration in order to succeed in the campaign to prevent HIV/AIDS.

6.6.2 Personal preference or distaste for using condoms

Table 6.13 (Annex A) presents the personal preference or distaste for using condoms among male migrants who are users of condoms with different types of sexual partners. The majority of migrants (70 to 75 percent) report that condoms reduce pleasure. Although the figures are similar for all partners, a condom is seen as reducing pleasure the most among migrants who have sexual intercourse with non-regular partners, and the least with sex workers. Probably because of the higher level of intimacy and trust among non-regular partners than sex workers, the promotion of condom use may be more difficult among migrants who have sex with girl friends than with sex workers. Again, this points to the more complicated program for the general public than on concentrated groups such as sex workers and their clients.

6.6.3 Negotiation skill and process of using condom with partners

Table 6.14 (Annex A) presents information on the negotiation skills that migrants feel that they have to convince partners to use a condom. The analysis is restricted to users of condom with different types of partners. It is found that most migrants feel that they can convince partners to use a condom. Although the number of female migrants who are users of condoms is small, and the analysis of the data has to be made with caution, there is no evidence here that women expect to have a more difficult time than men in convincing their partners to use condoms.

However, even though these migrants are confident that they can convince their partners to use a condom, in a situation where their partners do not want to use a condom, the proportion of migrants who say that they can deny sexual intercourse is only 61 to 84 percent (Table 6.15 Annex A). Migrants tend to compromise with their partners not to use condom. Male migrants compromise with their girl friends more than with sex workers. With sex workers, 80 percent of male migrants from Myanmar and 92 percent of male migrants from Cambodia report that they could refuse sexual intercourse if a sex workers did not want to use a

condom. Only about 60 percent of male migrants said that they could refuse sex with their girl friends in the same situation.
Table 6.16 (Annex A) provides summaries of this hypothetical situation by presenting data on the reported decision of migrants whether to deny or accept sexual intercourse in a situation where their partners refuse to use a condom. In sexual intercourse with regular partners, a large minority of migrants (about 30 percent), state that they would accept to have sex without a condom. The others report that they would either refuse to have sexual intercourse (23 percent) or keep trying to convince their partners until they agree to use a condom. Although data for the analysis by sex of migrants are small in number, and therefore interpretation has to be made with caution, women tend to be forced to compromise with their regular partners, and accept the risk of not using a condom, more than do men (39 compared to 26 percent respectively).

In condom use with sex workers, about 10 percent of male migrants would give up and accept the risk of not using a condom if sex workers did not want to use a condom. Only about two-thirds of men state that they would refuse to have sex. Cambodians are more likely to refuse than are Burmese migrants. About 86 percent of male migrants from Cambodia would say no, whereas only about 57 percent of male migrants from Myanmar living in the same coastal provinces would do the same. As discussed in an earlier chapter, Cambodians are more exposed to the HIV/AIDS prevention campaign, probably from their country, than are migrants from Myanmar and this might contribute to the greater negotiation skills of Cambodian migrants.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