

Adolescent Migrants in the Greater Mekong Sub-region : Are they equipped to protect themselves against sexual and reproductive health risks?



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
KAP	Knowledge, Attitude and Practice
OBGYN	Obstetrics and Gynecology
RH	Reproductive Health
RTIs	Reproductive Tract Infections
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
WHO	World Health Organization
VD	Venereal Diseases

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Preface

After the International Conference on Population and Development (ICPD) in 1994, many governments acknowledged the importance of reproductive health programs for national and regional development and laid down frameworks for their implementation. New components were also begun, such as initiatives for adolescents (aged 10-24 years). However, of this larger group of “adolescents,” adolescent migrants have not been adequately addressed as a distinctive group in terms of the design and delivery of reproductive health information, education and services. To a great extent, they are a neglected group. To understand the livelihood of adolescent migrants and their reproductive health practices, therefore, is a major area of increasing need.

Several organizations and countries within the Greater Mekong Sub-region have recognized the importance of addressing the reproductive health needs of adolescent migrants. In these countries, adolescents comprise a large proportion of rural to urban migrants, and they are particularly at risk of such reproductive health threats as HIV/AIDS. Consequently, a collaborative Multi-Centre Study on adolescent migrants and reproductive health was undertaken in four countries of the Greater Mekong Sub-region, namely, China, Lao PDR, Thailand and Vietnam. In addition to conducting research on adolescent migrants and reproductive health, the objectives of this joint study also included research capacity strengthening and the development of institutional linkages.

This book is the final report of this collaborative multi-centre study. It disseminates the results of the projects in the four countries to the public, to governments and to international agencies in order to foster a greater understanding of the livelihoods of adolescent migrants, their reproductive health practices, and their need for better information, education and services. It is hoped that the information in this book will improve reproductive health policies and programs and, ultimately, will lead to healthier lives for adolescent migrants.

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We gratefully acknowledge the great contributions of the late *Dr. Alan Gray* who started the project, but could not finish it. Our memories of him are kept alive by our research, analysis and interpretation of the lived experiences of adolescent migrants in four countries.

The respondents (adolescent migrants and health providers) in Yunnan (China), Vientiane (Lao PDR), Bangkok (Thailand) and Ho Chi Minh City (Vietnam) deserve our sincerest gratitude. We also would like to thank *Ms. Jenny Perrin* for her continuous efforts and assistance throughout the project. A special note of thanks also goes to *Ms. Aurapan Hunchangsith*, *Ms. Chutakarn Atitananan* and *Ms. Charuwan Charupum*, for accounting and administrative assistance as well as *Ms. Juntanee Paneetjit*, *Ms. Sukanya Suwansri*, *Ms. Somying Suvannawa* and *Ms. Phakaporn Putthgosa* for their secretarial and logistic assistance.

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The Multi-Centre Study Research Teams

The Multi-Centre Adolescent Migrant Study

*Bencha Yoddumnern-Attig, Chanya Sethaput, Supanee Pluemcharoen and
Jirakit Boonchaiwattana*

BACKGROUND OF THE MULTI-CENTRE STUDY

This book presents the results of a research project entitled, “The Regional Research Initiative on Adolescent Migrants in the Greater Mekong Sub-region.” The Institute for Population and Social Research (IPSR), Mahidol University, Thailand, coordinated this initiative, with support from the Department of Reproductive Health and Research, WHO, Geneva. Under this initiative, a joint Multi-Centre Study on adolescent migrants and reproductive health was undertaken among four countries in the Greater Mekong Sub-region (China, Lao PDR, Thailand, and Vietnam).

The project originates out of a concern for the sexual and reproductive health of adolescents – one highlighted at the International Conference on Population and Development (ICPD) held at Cairo in 1994 – and, in particular, the sexual and reproductive health of adolescent migrants. In many, if not all, countries in the Greater Mekong Sub-region, adolescents form a significant part of the labor force, one that is becoming increasingly important as the effects of globalization take hold in each country. Most of these young people, moreover, enter the rural to urban migration stream, as they are attracted to cities where they feel that work in industries and services can provide them with a relatively lucrative income. Away from their communities of origin, moreover, they have the chance to gain new experiences and form new relationships at a time when they are particularly vulnerable to such threats as unwanted pregnancy, STIs and HIV/AIDS (Bott and Jejeebhoy, 2003; Soonthorndhada et al., 2005; UNESCAP, 2006; United Nations, 2005; WHO, 2006). For those who succumb to these threats, it is not uncommon that existing health services are not equipped to provide them with the sexual and reproductive health information and services they so desperately need, largely because health providers do not understand the lives and livelihoods of adolescent migrants and the challenges they are face.

To shed greater light on the plight of adolescent migrants and their reproductive health, the Multi-Centre Study consisted of three linked components: research, training and advocacy. Its objectives were: 1) to conduct a multi-centre joint research study on adolescent migrants and reproductive health, 2) to strengthen social science research capacity in the four participating countries, and 3) to recommend to policy makers strategies for improving reproductive health care among adolescents, and especially adolescent migrants in each country.

PROCESS

To achieve these objectives, the project comprised three main parts. *Part I* entailed undertaking workshops to initiate the joint research projects in each country. These workshops centered on proposal writing, research methodology, data analysis and report writing using examples of data from each country. *Part II* concentrated on building technical co-operation and promoting human resource development by monitoring the progress of each research study through workshops and electronic communications. *Part III* centered on disseminating the research findings by holding regional seminars for reproductive health planners and related personnel.

Using a common approach, the studies in the four countries were restricted to only one large urban area, but one that would provide a variety of different settings. Within this area, the major study sites comprised locations where adolescent migrants usually cluster. Within this context, the studies sought to identify the reproductive health risks of adolescent migrants and the barriers to their access to information, knowledge and services. Based on this information recommendations could be made on what could be done to increase their access to information on reproductive health and to reproductive health services, as well as, ultimately, to reduce reproductive health risks among adolescent migrants. Some of the major findings from this Multi-Centre Study are:

1. Adolescent migrants are at greatest risk when they are contemplating marriage.
2. Adolescent perceptions of risk and lack of information and services limit their ability to protect themselves against sexual and reproductive health risks, including prevention against HIV/AIDS, STIs and unplanned pregnancies.
3. Nonetheless, several mechanisms exist that impart some level of protection against reproductive health risks, such as self-control, as well as familial and social network control.
4. Programs and activities to equip adolescents to protect themselves against reproductive health risks should cover two significant periods, that is, before moving and after moving into urban cities. *Before moving*, orientation programs or activities should be conducted to prepare young adolescents for their livelihood in urban cities. *After moving*, adjustment programmes or activities should be conducted to assist adolescent migrants in sustaining their *livelihood* which includes *laboring* (working hard), *living* (living management skills) and *loving* (RH practices and risks).

These findings, amongst others, are some of the urgent areas for improvement that policy makers, programmers, researchers, interventionists and other concerned organizations should seriously address.

In addition to generating study findings, the Multi-Centre Study also focused on research and capacity strengthening and the establishment of a collaborative network. Even after its completion, the study is strengthening institutional linkages between the four countries and their research centres, while at the same time building a clearer picture of the commonalities and differences in adolescent reproductive health issues in the region. Currently, the initiative is at the stage of planning operations research studies based on the Multi-Centre Study findings. There will be six countries participating in the second phase: Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam.

ORGANIZATION

This book contains seven chapters. *Chapter 1* describes the background of the Multi-Centre Study and its process. *Chapter 2* presents a situation analysis related to adolescents, and adolescent migrants in particular, in each of the four participating countries and highlights gaps in knowledge that, if filled, could improve the reproductive health of this important population group. *Chapter 3* offers a clear picture of how socio-cultural contexts can have a powerful impact on the reproductive behaviors and risks of Chinese adolescent migrants. *Chapter 4* presents the views and concerns of adolescent migrants from Lao PDR, as well as the urgent need for reproductive health information, education and services for this group. *Chapter 5* continues with this theme through the voices of adolescent migrants and health providers in Bangkok, Thailand. They unanimously agree that lack of privacy and confidentiality at health facilities is a major barrier to accessing reproductive health services, one that must seriously be addressed if lasting improvements in reproductive health are to be made. *Chapter 6* shows that time lost and treatment cost are major complaints that significantly block adolescent migrants in Ho Chi Minh City, Vietnam, from using reproductive health services. In addition, doctors' attitudes and the heavy workload of health personnel complicate this situation further. Finally, *Chapter 7* synthesizes findings and assesses the situation of adolescent migrants in the four participating countries as to whether or not they are equipped to protect themselves from reproductive health risks. Analysis of the data yields a mixed picture in terms of both protection and risks.

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Why Focus on Adolescent Migrants?

Chanya Sethaput and Supanee Pluemcharoen

INTRODUCTION

According to World Population Prospects, the world contains 1 billion young people between the ages of 15 and 24 years, or nearly 18 percent of the world's population. International concern about the reproductive health needs of young people dominated the International Conference on Population and Development (ICPD) in 1994, and young people were identified as a particularly vulnerable group. In Asia as well, the sexual and reproductive health of young people has emerged as an issue of great concern, fuelled, on the one hand, by the spread of such diseases as HIV/AIDS, and, on the other, by the neglect of existing health services to provide for young people's sexual and reproductive health needs. Consequently, providing such services and undertaking research to understand the sexual behaviors and reproductive health of young people has become a public health priority in many Asian countries. Moreover, it is also a priority for national development. Globalization is embracing each of the countries in the Greater Mekong Sub-region – China, Lao PDR, Thailand and Vietnam – that is resulting in rapid socio-economic changes within the countries and within the communities in which young people live. As with the global picture, young people make up a large proportion of the populations in these countries and are the backbone of national labor forces. They are also influenced by cultures other than their own, which leads to continuing changes in their livelihoods and lifestyles.

ADOLESCENTS AT RISK

Adolescence is a period during which physical, mental, social and intellectual changes occur. The World Health Organization classifies "adolescence" into three stages: *early adolescence* (10-15 years of age) is characterized by spurts in physical growth; *middle adolescence* (16-19 years of age) is comprised of wide mood swings, the growing influence of peers, interest in the opposite sex, complete physical change and sexual experimentation; and *late adolescence* (20-24 years of age) entails the development of gender role perceptions, independent living and working, and an increased interest in sexuality (Department of Mental Health, 2004).

Adolescents are assumed to be at risk of sexual and reproductive health threats because adolescence is a time of curiosity and experimentation, even though emotional maturity has not yet fully developed. Their growing sexual desires places adolescents at risk of engaging in premature sex and premarital sex, which can, in

turn, lead to such consequences as unwanted pregnancy, abortion, STIs and HIV/AIDS (Department of Mental Health 2004).

Physically, adolescence can be a healthy stage of life. However, the health of young people is closely linked with lifestyle changes and the adoption of new behaviors. The start of sexual relationships, whether safe sex is practiced, eating habits, level of physical activity, and the use of cigarettes, alcohol and other psychoactive substances can damage the health of adolescence, the consequences of which can last a lifetime (WHO/UNFPA UNICEF Study Group, 1999).

As mentioned above, the reproductive health of adolescents is of growing concern today due, in part, to the trend towards a rise in the age at marriage which increases the period of adolescence before marriage. The second concern is the declining age at menarche which leads to an earlier onset in adolescence, sexual maturity and the ability to reproduce. The widening gap between age at menarche and age at marriage increases the possibility that young people will engage in premarital sexual activity. Most sexual intercourse among adolescents, moreover, is unprotected and can lead to unwanted pregnancy and abortion. Sexually active adolescents are also increasingly at risk of contracting and transmitting STIs including HIV/AIDS (Gubhaju, 2002).

In **China**, the report of a UNFPA Workshop (2000) on adolescent reproductive health highlighted the factors that influence the sexual behavior of Chinese adolescents, most notably the desire to be independent in making their own decisions, as well as the belief that sex is a way to demonstrate “true love.” Focus group discussions with young unmarried women in rural areas found that premarital sex was accepted only if the man and woman were going to get married, which follows a widely-practiced custom in parts of rural China where men and women after living together then become engaged and hold a formal wedding ceremony (Tang, 1999 cited by Zhenzhen, 2001). Teenage pregnancy occurs largely because of poor knowledge of pregnancy prevention. If a girl becomes pregnant, she would often have an abortion in a private clinic and not in a hospital where parental consent is required. While the knowledge of family planning and AIDS appears to be high, that of STIs as well as knowledge and where to go for ARH services are very low (UNFPA, 2000).

Lao PDR is also a country in transition, experiencing a variety of rapid and progressive social changes that affect young people. Laotian adolescents are vulnerable because they lack access to acceptable, affordable and appropriate reproductive health information and services. A national survey on adolescent reproductive health in Lao PDR (2000) revealed that 70 percent knew that sexual intercourse led to pregnancy, but 44 percent did not know that unprotected sex could lead to pregnancy, and 33 percent did not realize that a woman could become

pregnant at first intercourse. The survey results showed that a low percentage of respondents (17 percent) had ever discussed sex at home while they were growing up (WHO, 2005a). Independent research on sexual behavior among youth in Vientiane found that most male and female youth who were sexually active agreed that they did not plan to have sex; almost half of them had never used a condom (Sychareun, 2002, cited in WHO, 2005a). A study among community members revealed that sex and pregnancy before marriage were common and more or less accepted because of the common belief that pregnancy outside marriage leads to marriage (Sananikhom et al., 2000).

In **Thailand**, rapid economic and social transformations have been changing the way of life of the Thai people. The emergence of the nuclear family has led to diminished social support and the increased vulnerability of youth. Drug addition and crime are on the increase, as are premarital sex, unsafe abortion, unwanted pregnancies, HIV/AIDS and STIs (FOCUS on Young Adults, 2001). Most adolescents do not have access to factual knowledge about sex, so they lack basic knowledge and skills in analyzing the risk of engaging in premarital sexual activities and are unaware of self-protection. One consequence is that, according the report on Thai Health, 18,000 Thais were infected by the HIV virus. Most of these people were teenagers and students aged 15-24. At present, more than 30,000 Thai teenagers are HIV-positive. Of these, 84 percent contracted the virus through sexual intercourse (Kanchanachitra, et al., 2006).

In **Vietnam**, the introduction of the economic reconstruction policy known as the *Doi Moi* has resulted in greater exposure to western culture, which directly affects young people. There has been an increase in premarital sex and pregnancies among adolescents. A study of adolescents (15-19 years old) in Hanoi found that 15 percent of respondents had experienced premarital sex. The study also found that 80 percent of pregnant girls under 20 did not know that they were pregnant. Furthermore, adolescent knowledge about reproductive and sexual health, as well as their negotiation skills for safe sex are still inadequate. The low level of contraceptive use among sexually active unmarried adolescents also has been reported in several studies. A 1996 KAP survey of 1,464 students aged 15-19 in Ho Chi Minh City, for instance, found that only 37 percent of students knew about contraceptives. Young people, and especially rural adolescents, have limited access to reproductive health information and services. Some young people believe that it is easier to obtain an abortion than to use contraception on a regular basis (WHO, 2005b).

ADOLESCENT MIGRANTS AT RISK

In fact, not all young people or adolescents are equally vulnerable. While adolescence is a critical period, migration is another life course event that can have profound implications for sexual and reproductive health. The rural areas of

countries in the Mekong Sub-region are home to many poor people. In these areas, out-migration from the countryside to urban areas has occurred in reaction to natural resource depletion, calamities, civil conflicts, poverty and other pressures on rural life (Dang, 2003). In many cases, poor people, and especially young ones, move from rural communities to seek jobs in cities in the hope of gaining a better life. Although they often have social networks comprised of relatives or friends to help them to cope with urban life, these same networks are not used when faced with reproductive health related decisions.

Before these young people move to cities, they usually have little or no sex education in their places of origin, such as through schools or from their parents. As a case in point, a study in rural Northeast Thailand, where migration from villages to cities is very high, revealed that rural mothers provided very little knowledge about reproductive health and premarital sex to their daughters (Sethaput and Pattaravanich, 1993). This lack of knowledge, and the fact that they were away from their families and communities – and thus social control – increases the likelihood of premarital sex and its reproductive health consequences. Within the education system, furthermore, administrators are still debating whether or not sex education should be provided to primary and secondary level students, be they rural or urban. Nonetheless, urban young people and a growing number of their rural counterparts, including migrants, are being exposed to sexual information through the mass media and the Internet. Unfortunately, however, migrants cannot easily access information about sexual health, due to inadequate knowledge about it and lack of services to deal with the sexual and reproductive health of young people. Traditionally, reproductive health services have been oriented largely towards providing for the needs of pregnant married women. Consequently, young people, and especially sexually active male and female adolescents, do not seek such services for reasons that include inconvenient schedules and locations, lack of privacy and confidentiality, fear of social stigma, the judgmental attitude of service providers and unaffordable fees (United Nations, 2004).

In the Greater Mekong Sub-region, several studies on adolescents have been conducted but mainly focusing on in-school youth or students. Very few focus on adolescents migrants specifically and, even less so, on their reproductive health concerns.

In **China**, rapid economic growth in urban areas has increased the income disparity between urban and rural areas that, in turn, has encouraged rural residents to migrate to urban areas in search of a better life. Rural migrant workers and their families are presumably registered and given a household registration booklet in order to claim their social benefits, such as access to health care and education. In reality, though, some migrants remain “outsiders” in urban areas. Those living outside of the household registration system are known as a “floating population” (Dang, 2003).

They thus are not covered by social welfare programs and have little access to health services.

Information on the sexual risk behavior of vulnerable groups, such as migrants, and comparative studies on the perspectives of adolescents, parents and health providers have revealed emerging reproductive health problems among poor migrants. Though not an academic source, the Shanghai Daily (February 2004) reported that local officials called for improved sex education for the city's growing migrant population after a survey suggested many migrants (aged 15-24) in Shanghai had little understanding of contraception and sexual diseases. About 90 percent of unplanned pregnancies led to abortions. Local hospital authorities reported that a growing number of migrant women sought abortions over the last two years.

A study focusing on female migrant workers under 25 years of age in five urban areas of China pointed out that premarital sex was not unusual among unmarried young migrant workers. However, contraceptive awareness and use was limited; unwanted pregnancy and induced abortion were reported; and barriers to services identified (Zhenzhen et al., 2001), including fear and embarrassment of disclosure, gender power relations, affordability and perceptions of a threatening service environment. Though these young migrants intended to use contraception, they had little access to contraceptive services. Moreover, most young migrants believed that unmarried persons were not eligible for these services. Though they felt embarrassed to buy contraceptives from drugstores, it was better than suffering the judgmental attitudes of health service providers if they sought contraceptives in private or government clinics. Thus, young migrant workers were blocked from using contraception due to many factors, such as the traditional culture, special migrant social status, lack of medical insurance or basic benefits, lack of information and, sometimes, misinformation (Zhengzhen et al., 2001).

In **Lao PDR**, very little research has been conducted to look specifically at the reproductive health knowledge, awareness and behavior of adolescents, particularly rural and ethnic minority youth (WHO, 2005a). A national survey on adolescent reproductive health in 2000 revealed that knowledge of contraception among unmarried youth increased with age, and the knowledge of urban youth was higher than of their rural respondents. About half of the respondents considered sex before marriage to be unacceptable. Among rural respondents, they suggested that the girl should marry the man who made her pregnant in order to keep her family from becoming shamed (WHO, 2005a). For sexually experienced adolescents aged 15 to 25, as many as 79 percent did not use any contraceptive method at first sexual intercourse (Sisoupanthong et al., 2000).

An independent research study on sexual behavior among youth in Vientiane found that more unmarried male youth had engaged in sexual intercourse than females

(Sycharurn, 2002 cited by WHO, 2005a). About 17 percent of sexually active men had more than one partner during the previous twelve months. Almost half of them had never used a condom. Findings from focus group discussions with 18 to 24 year old youth who used contraceptives noted that respondents preferred to obtain contraceptives from pharmacies rather than from government hospitals. Another focus group study on HIV/AIDS care and support for marginalized and mobility affected people in Vientiane City and Bokeo Province highlighted that youth preferred private sector care because of privacy, confidentiality and anonymity, which could not be found at government hospitals (WHO, 2005a).

In **Thailand**, Bangkok and its vicinity attract a large number of young, seasonal migrants during the slack agricultural season as a means for supplementing household income in rural areas (Chamratrithirong, et al., 1995; Isarabhakdi, 2000; Richter, et al., 1997). Generally, migrants were satisfied with their move although they questioned their quality of life after migration (Chamratrithirong, et al., 1995).

Yet, migration is not always a preferred strategy, nor a safe one. Most young migrants have finished only six years of compulsory education, so they lack educational and vocational skills. Moreover, qualitative evidence has shown that many migrants would prefer to stay home if they could earn a sufficient income, because life in Bangkok is not pleasant and it incurs a high cost of living (Richter et al., 1997). Even though migrants living in Bangkok have access to social network support to cope with urban life, this network does not shield them from sexual and reproductive health risks, including HIV/AIDS infection (Dixon-Mueller, 1996). Studies have shown, moreover, that most migrants feel that they are more at risk of HIV/AIDS infection than non-migrants, and male migrants are slightly more at risk than female migrants (Richter et al., 1997). Among adolescent female factory workers, concerns about unwanted pregnancy and STIs play a role in whether or not they will enter into a sexual relationship with a boyfriend. For those deciding to do so, and to use contraception, they were more concerned about appropriate places where they could go for services rather than the methods that they should use. They would think about confidentiality and privacy first when they were in need of family planning (Soonthorndhada, 1996).

A study of electronic factory workers aged 15-24 near Bangkok (Suparp et al., 1992 cited by Gray and Punpuing, 1999) revealed a high level of premarital sexual experience, especially male workers who had visited sex workers. Twenty-two percent of all male respondents had contracted STIs compared with 0.6 percent of the female adolescents. While over 80 percent reported that they used contraception, 9 percent reported that premarital pregnancy had occurred and 5 percent reported that they had terminated their pregnancies through induced abortion.

A study by Ford and Kittisukhsathit (1996) suggested a growing plurality and complexity in young people's sexual lifestyles and networking. The very low level of condom use within increasing non-commercial pre-marital intercourse within loving relationships is of special health concern. The obstacles to 'safer sex' included lack of perceived risk, desire for a sense of trust and intimacy, and low level's of communication between partners concerning contraceptive use.

In **Vietnam**, and in response to the *Doi Moi*, which was officially lunched in 1986 and driven by poverty and scarce resources, the rural workforce has increasingly migrated to the country's largest cities of Hanoi and Ho Chi Minh. The household registration system, similar to the Chinese model, no longer limits acquisition of essential goods and residences in cities. Some migrants are considered as "temporary residents" based on their duration of stay in the cities. Only a few who migrated to Ho Chi Minh City had obtained a permanent residence permit (Dang, 2003).

The bulk of studies on adolescents in Vietnam focus mainly on in-school adolescents. Studies on out-of school youth such as adolescent migrants and service providers' perceptions and behaviors are lacking. Nonetheless, there is a growing body of unpublished research as well as several published studies based on clinical or collective samples (such as single women presenting for abortion services in urban hospitals) that focus on adolescent reproductive behavior in Vietnam (Mensch et al., 2003). Yet, none of these specifically center on adolescent migrants who are at particular risk and represent a large proportion of the population in urban centers.

Some published articles on youth risk behaviors in Vietnam note a rise in pregnancies among unmarried women, the termination of unplanned pregnancies, prevalence of HIV infection, as well as condom use (Goodkind, 1994; Goodkind and Anh, 1997, cited by Mensch et al., 2003). Among Vietnamese adolescents, in general, an unpublished report of a qualitative study of 120 adolescents in two provinces of Vietnam found that adolescents had inadequate knowledge about contraceptives. Female adolescents thought they would seek abortion services in case of pregnancy. Male adolescents, including those having sex with commercial sex workers, did not use condoms because they wanted to maintain sexual pleasure (Population Council, 1997).

According to a survey on Adolescents and Social Change (VASC) covering 2,126 young people aged 15-22 in 6 provinces – including Ho Chi Minh City, Vietnam's largest and most economically active city – a high level of premarital sex was noted among unmarried boys aged 15-19 years, even though premarital sex is socially stigmatized. Adolescents in Ho Chi Minh City seem more vulnerable than those in other provinces because many nightclubs and karaoke bars have opened in recent years.(Mensch et al., 2003).

CONCLUSION

The proportion of young people aged 15-24 years old, or adolescents, is high and is estimated to continue to increase. Their sexual and reproductive health needs and problems are of great concern because adolescence is a period of transition from childhood to adulthood. This is also the age when most young people begin to explore their sexuality and to enter into sexual relationships. Sexual activity during adolescence puts adolescents at risk of sexual and reproductive health threats including early pregnancy, unsafe abortion, STIs, HIV/AIDS, sexual coercion and violence. Nearly half of 4.9 million new HIV infections each year occur among people aged 15-24 with a higher rate of incidence in young women than in young men (WHO, 2006). While adolescents are at risk as a single group, those who migrate out of their rural communities and into large cities are most at risk. They come with little knowledge or skills about the sexual and reproductive health risks. In addition, their access to quality services is limited, even though these services are more numerous than in their rural communities. Powerful barriers include distance, location, cost, inconvenient operating hours that may conflict with the migrants' working hours, the perceived unfriendly and judgmental attitudes of service staff, and lack of confidentiality (WHO, 2006).

To shed greater light on this situation, a joint multi-centre research study on adolescent migrants and reproductive health was conducted in the Greater Mekong Sub-region, namely, China, Lao PDR, Thailand and Vietnam with the support from the World Health Organization in Geneva. The objectives of this study were:

1. To identify adolescent migrants' risk of practicing unsafe sex leading to unwanted pregnancy, sexually transmitted infections/diseases and reproductive tract morbidity;
2. To identify barriers to their access to information on reproductive health; and
3. To evaluate their access to reproductive health services.

The study's primary target group were adolescent migrants aged 15-24 years either male or female, married or unmarried. They were living either with friends, relatives or spouses in the urban areas of Kunming (China), Vientiane (Lao PDR.), Bangkok (Thailand) and Ho Chi minh City (Vietnam). The study's secondary target group was service providers.

In order to gain an in-depth understanding of adolescent migrants and their reproductive health situation, qualitative research methods were used entailing in-depth interviews and focus group discussions. All of the interviews and focus group sessions received the voluntary consent of each respondent. The results of the country studies are presented in the following chapters.

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Adolescent Migrants and Reproductive Health in PR China: The influence of socio-cultural contexts

Qiao Henrui, Fan Jian, Gu He and Wu Yunmei

INTRODUCTION

Reproductive health remains a new concept in China. In the *State Report of Population and Development of China*, published by the National Population and State Family Planning Commission of China on 7 September 2004, the concept of reproductive health was incorporated into the country's population program. At present, reproductive health and AIDS prevention for disadvantaged groups, especially migrant populations, women and the poor, remain very important and urgent challenges.

According to the 2000 Census, the migrant population has reached 140 million, equal to 10 percent of the total population. Young people aged 15 to 35 make up more than 70 percent of the total migrant population. Movements are mainly from rural to urban areas, and the reasons are mainly for work or business.

Since the 1950s, China has implemented a special resident/household registration system by people's living location. Influenced by the household registration system, migrants face many obstacles in employment, education, social welfare and medical care including reproductive health services. At present, there is not a complete system of medical care and social welfare in China. Only 10 percent of the total population is covered by the social and medical care system, while rural and poor people, which form the majority of the population, lack coverage. As a result, when people move from rural areas to urban areas, they cannot receive even basic medical insurance. According to the State Report of Population and Development of China, the government of China will comprehensively address services for medical care and reproductive health in 2005, with the objective of forming a basic service system of medical care and reproductive health covering the entire population in 2010.

Since the family planning policy has been carried out for many years, there is a complete network of technical services for family planning in China, including Yunnan. Using this network is a way for the government to provide medical care and reproductive health services to migrant populations in the future.

Influenced by the household registration system, migrants face many obstacles in employment, education, medical care (including RH services) and social welfare.

Yunnan is an undeveloped province, with a relatively sluggish economy. The first HIV-infected person in Yunnan was discovered in 1989. In 2003, the provincial report announced that the number of HIV-positive people had reached 13,241. Relevant experts estimated that the real number was approximately 70,000 and was the highest in China. Preventing HIV/AIDS has been an important task for the provincial government. One-tenth of the entire population of Yunnan is situated in Kunming City. According to data from the Fifth Population Census in 2003, the total population of Kunming is 5,781,294, and the migrant population is 1,771,328, accounting for 30.6 percent of the total. The migrant population, especially the adolescent migrant population in Kunming is a key group for preventing reproductive health threats and STIs and HIV/AIDS, in particular.

Migrants comprise 31 percent of Kunming's total population.

PREVIOUS STUDIES

Some research on the reproductive health of migrant populations has been undertaken in China in recent years, but most has been conducted in big cities in eastern coastal areas and has lacked thorough analysis.

In examining the causes for migration, a study of rural migrants, sponsored by Deutsche Gesellschaft Fur Technische Zusammenarbeit (GTZ), revealed two main reasons for rural-to-urban migration. One reason is the lack of job opportunities in rural areas; nearly all rural migrants are surplus laborers from traditional agriculture. The other reason is poverty. The rural migrants hope to avoid a poor life in rural areas by moving into and working within a prosperous urban environment (unpublished report of Yunnan Urban Poverty Study).

Concerning sexual behaviors and contraceptive use, an investigation of migrant workers' sex behaviors in Guang Zhou, which was undertaken by the Institute for the Science and Technique of Family Planning in Guang Dong Province, indicates that 50 percent of young female workers have had premarital sexual experiences, and 30 percent of males do not use any contraceptive methods. In the group of female migrant workers who have boyfriends, 85 percent have had sexual experiences; 70 percent have lived with their boyfriends without being married; and 30 percent have had abortions (Zheng Lixing, 2003).

Recently, an investigation of one thousand female migrants aged from 15-24 years, which was done by the Institute of Family Planning Science, Shang Hai Academy of Sciences, indicates that nearly half of all female migrants admit that experienced an unplanned pregnancy, mainly because they had not used any contraceptive. The study also notes that one-quarter of pregnant female migrants went to private clinics or took medicines by themselves to have an abortion (Gao Zhiguo, 2004).

Data from hospitals indicate that among patients suffering from STIs, over 80 percent are migrants and 70 percent are male (GDPIC, 2003). Migrants also have limited knowledge of reproductive health. Only 5 out of 59 female workers interviewed knew that condoms can protect sexual partners from AIDS, and 85 percent think their friends could not have reproductive diseases. Thirty percent of female migrant workers knew nothing about possible illnesses caused by abortion (GDPIC, 2003).

BACKGROUND INFORMATION ON MIGRANTS IN KUNMING

Kunming is the capital city of Yunnan Province. Its income comes mainly from tobacco and tourism. It is famous in China for its mild climate and natural beauty. The migrant population of Kunming has been increasing in recent years. According to data from the Fifth Population Census in 2003, the migrant population in Kunming is 5,781,294, comprising 30.6 percent of the total population, which is 17,713,280. Migrants are scattered across Wuhua, Panlong, Guandu and Xishan districts. There are particularly large concentrations in Guandu and Xishan, which are on the outskirts of the city. Migrants account for 48.84 percent of the population of Guandu, 17.9 percent of the population of Xishan, 10.3 percent of the population of Wuhua, and 8.0 percent of the population of Panlong. Sixty-eight percent of migrants are male and 32 percent are female. Altogether, 9.4 percent of migrants are aged 16-20, 72.6 percent are aged 20-35, 13.1 percent are aged 36-45, and 4.9 percent are aged 46 or more. Their educational levels are mainly primary and junior secondary. Seventy-three percent of migrants have received junior secondary education. Ninety-five percent of migrants are workers; 3 percent are in business; 1.5 percent are in service industries, and 0.5 percent of are in other jobs. Since industries and services in Kunming are undeveloped, the ability to absorb labor is limited. In fact, the jobs that migrants take are mainly manual work, such as building and carrying. The majority of migrants are from poor rural areas. Forty-nine percent are from Yunnan; 34 percent and 9 percent are from Sichuan and Guizhou provinces, respectively, which have borders with Yunnan; and 8 percent are from other provinces in China.

In summary, young people form the majority of the migrants in Kunming. They mainly cluster in areas connecting the outskirts and the city. The majority of migrants are young men. They generally have limited education. They are mainly from the poor rural areas of Yunnan and other provinces bordering Yunnan. They work mainly by using physical strength and usually receive low pay.

Sixty-eight percent of migrants in Kunming are male and 32 percent are female.

Altogether, 9 percent of migrants are aged 16-20, and most are in the working age group.

METHODOLOGY

Understanding the conditions and reproductive health needs of the migrant population is undoubtedly important, as it can benefit policy formulation and the provision of services. For this study, data on adolescent migrants and their reproductive health were collected in line with China's research plan for the Regional Research Initiative on Adolescent Migrants and Reproductive Health in the Greater Mekong Sub-region. Qualitative data were collected through in-depth interviews with adolescent migrants from three communities where many migrants live. These communities were Fude, Xiqiao and Xiba. In total, 79 adolescent migrants were interviewed, namely, 40 men and 39 women. In addition, 13 doctors and nurses involved in reproductive health services in public hospitals, family planning community service centers, and private clinics were interviewed to solicit their perspectives on adolescent migrants and use of reproductive health services. In addition, we drew on existing research on the reproductive health of migrants conducted around China in recent years, as well as documents on policies of the various levels of government in China. Investigations and dissertations from research institutes, as well as the records of the government, were other main information sources.

RESULTS

In this research study, two aspects of the reproductive health of adolescent migrants are emphasized: personal factors and social factors.

Personal Factors

Gender Differences

Traditional gender roles

Both male and female adolescent migrants face reproductive health problems, but their concepts, attitudes and actions towards them are very different. The differences may be rooted in physical conditions, status and responsibility, and influenced by socio-cultural contexts.

In traditional Chinese culture, and especially in rural areas, men are thought to be more important than women. Regarded as the mainstay of the family and the master of the house, the man has greater power than the woman, who is mainly the assistant to the man, as well as manager of the housework. In addition, men and women in China usually have different attitudes about love. Men emphasize "career is more important" and "who has a stable job has steady love," while women think that "I love someone single-mindedly," "if I love someone, I could go anywhere with him."

Premarital sexual relationships

Although the majority of male and female migrants realize that it is common to have sex before marriage, there is a noticeable contrast among the female migrants in how they view it. Some think “it is something dishonorable,” “to lose her own dignity as well as her parents,” and worry about “pregnancy,” “being cheated by the man,” or “being abandoned by the man.” Others think that “you can’t control this kind of thing by reason,” or “as long as you want it, it is ok.”

Compared to their female counterparts, the attitudes of male adolescent migrants towards premarital sex are rather mild and relatively in agreement. They think “it’s normal,” “it’s not good but not bad.” Men do not consider female virginity a serious issue. They think that “there are few virgins now, and it is not realistic to take that into account.” Nonetheless, some male adolescent migrants think that females need to pay more attention to keeping their virginity, while female adolescent migrants emphasize the bad consequences of sex for themselves.

Though they felt that premarital sex is common, it is not yet widely accepted by female migrants. They are still concerned about dignity and unplanned pregnancy.

Most male and female migrants think that men and women have the same rights regarding sex. But what is noticeable is that some male and female migrants feel that men have greater rights than women when it comes to sex. In addition, most interviewees felt that a woman should be responsible for preventing unexpected pregnancies, because she will be directly influenced by it. In one female interviewee’s opinion, men do not have the responsibility for protecting women from unplanned pregnancies:

I don’t think that a man is responsible for protecting a woman from unplanned pregnancies. If he wants to have a woman staying with him, he should have a baby with the woman. However, the situation is different for the woman. She should take the responsibility for preventing herself from unplanned pregnancies, as pregnancies before marriage will affect her physical health.

In the case of unplanned pregnancies, male and the female adolescent migrants agreed that this was the responsibility of the woman, yet they differed on what the man’s parental role should be. In response to the question on what a man should do when faced with a woman who has his baby before marriage, female adolescents stated that the man should “care for,” “look after,” or “marry” her; while the male interviewees stated that he should give her monetary support. Remarkably, a minority of interviewees think that “money can solve every problem.”

Male adolescent migrants seem to enjoy greater reproductive rights than their female counterparts.

Reproductive health

Most adolescent migrants lack basic knowledge about reproductive health. There is no formal education about reproductive health in China, and thus students receive limited knowledge about reproductive health from school. In rural areas, many adolescents finish their education after they graduate from secondary school and some leave school early. In addition, their family members also seldom provide them with knowledge about reproductive health because of the influence of traditional culture and the restrictive social environment in rural areas. When these adolescents move to the city, they face a new environment. Here they can obtain some knowledge about reproductive health directly or indirectly, but most of knowledge is incomplete.

Unmarried adolescent migrants neither have RH education nor RH knowledge.

Although both female and male adolescents realize that men and women are responsible for preventing STIs and AIDS, the opinions of male adolescent migrants are more diverse than those of female adolescent migrants. Some of the male adolescents think that “the man should take the responsibility, since the infection in men is serious.” But for female sex workers, they feel that they should take more responsibility.

Pregnancy and abortion fall under the responsibility of female adolescents, while disease prevention falls under the responsibility of male adolescents.

Male adolescents usually think about actually confronting reproductive health problems, while female adolescents pay more attention to its consequences (i.e., changes in their relationship and other related health problems). Female responsibilities for these problems are emphasized by both females and males. For male responsibilities, however, the data are more diverse. Several male interviewees think that the man has greater responsibility for preventing the spread of STIs and HIV/AIDS. Apparently, men will pay more attention to their duties when they realize sex may cause reproductive health problems for them.

After migrating from rural areas to urban areas, women are always in a passive, disadvantageous position. They are faced with many potential reproductive health threats, and they must take sole responsibility for them. Some research studies indicate that women, and particularly single women, have experienced many reproductive health problems, such as premarital sex, unexpected pregnancies and abortion. Of course, the reproductive health problems of male adolescent migrants also need attention, even though those of female migrants often receive the

Moving from rural areas, female migrants are in a disadvantageous position with regard to their lives and reproductive health.

greatest consideration. In fact, some studies indicate that many of the patients who have STIs are male migrant adolescents.

Marriage and Reproductive Health

Marriage and childbearing

Marriage is an important factor influencing the reproductive health of adolescent migrants. Traditionally, large numbers of married people migrated with their families in China. In addition, because of the strict family planning policy in China, married adolescents and female migrants already receive substantial attention from government departments in areas that influence their reproductive health directly.

The life of married adolescents who migrate with their families is obviously different from that of unmarried migrant adolescents. In fact, the prospect of bearing children is an important reason for the migration of married people from rural areas. At present, a great number of married adolescents in rural areas still want to have boys. In order to evade the national family planning policy, which states that a woman from a rural family can bear only two children, some rural migrants move to cities to realize their hopes and bear more than two children, especially if they want a boy. Because of the responsibility for bearing and raising children, as well as the influence of the family planning policy and traditional culture, married female adolescents' sexual and reproductive health behaviors are much more constrained than those of married male adolescents. For example, a woman in a family bore three girls successively. Her husband was very angry and would not sleep at home until the woman bore a boy the fourth time.

Regarding the sexual relationships of married adolescents, the majority of married male and female adolescents believed that wives should satisfy their husbands' sexual desires even though they would not like to do so. In the views of female respondents':

“Wives are responsible for satisfying their husband.”

“I never initiate discussion about sex with my husband. It is up to him.”

“I should satisfy him since he is my husband. The reason why a man wants a woman is that he wants to have sex with her. Otherwise, what does a man want a woman for? If you love him, you should satisfy him. It is just a family and children that a man wants a woman for.”

Extra-marital sexual relationships

Differences exist in the opinions of married adolescents regarding the issue of extra-marital sexual relations. Most of the respondents were against it. As one male respondent noted, “I can’t accept it, because in a family, the husband and the wife must be responsible for one another, and the husband, as a man, is responsible for the family and himself. We must avoid it without any exception.”

However, a number of married adolescents noted that they can accept extra-marital sexual relationships when a man must work far away from home and for a long period of time. A married man, who admitted to having sex with a woman who is not his wife, said that he often comes across prostitutes in the evening when riding a three-wheel vehicle. “When a woman hugs you from behind or poses attractively in front of you, how can you control yourself?” A female adolescent also expressed the opinion that: “If the wife is sick and can’t have sex with her husband, it is forgivable that the husband has sex with another woman, but he must take responsibility for his wife and children.”

Some married adolescents said that they could understand a married woman having an extra-marital sexual relationship. A married female adolescent explained that: “Generally speaking, women are vulnerable. They need love and care which they can’t always receive from their husbands. If the husband and the wife can’t get along well with each other, it is forgivable for that to happen once in a while.” But while other adolescents, including some married female adolescents, could sometimes accept a married man having an extra-marital sexual relationship, they completely could not accept a married women doing so.

Accordingly, some married adolescents think that a married man has more rights regarding sex outside of marriage than a married woman. A male adolescent said that “a woman can have the same rights as a man before marriage, but they cannot after marriage, because a married woman is not the same as a married man.” Generally speaking, a man who has extra-marital relationships is more likely to be forgiven than a woman who behavior is constrained by prevailing gender norms.

Generally speaking, the act of marriage should confine sexual relationships to between the husband and wife. However, because of the gender inequality of men and women, married men are freer to have extra-marital relationships than married women. Married men also have absolute authority concerning sexual relations with their wives. Due to wives’ submissiveness, husbands’ authority and rights regarding sex are continuously maintained. The ability for a husband to

Marriage gives a clearer picture of the inequality between male and female adolescents in relation to sexual relationships and reproductive health.

have extra-marital relationships also raises the risk of his contracting STIs or HIV/AIDS and then transmitting them to his wife.

Reproductive health

Because of the family planning policy, married adolescents face many more contraceptive problems than single adolescents. The majority of married adolescents think women should be responsible for contraception rather than men. “Contraception is a woman’s business.” At the same time, women are the main target of contraception campaigns undertaken by family planning agencies.

Compared with single adolescents, married adolescents (and particularly married female adolescents) pay more attention to the effects of AIDS and STIs on family members and children. They mentioned that the best way to deal with these problems is to divorce or to live apart.

Though adolescent migrants know little about reproductive health, female adolescent migrants tend to know more about reproductive health than males, and married ones know more than unmarried ones. When protecting females from unplanned pregnancy was discussed, only a few unmarried adolescent migrants, especially males, could name some type of contraception. On the contrary, the majority of married adolescent migrants mentioned some type of contraception, possibly because this group is influenced by family planning, and they receive some reproductive health services and contraception voluntarily or involuntarily. Nonetheless, although married migrants can obtain more knowledge about reproductive health from family planning workers, most information concerns contraception for married women and is thus incomplete.

For married adolescent migrants, their source of RH knowledge mainly comes from family planning workers.

Unmarried adolescent migrants’ knowledge about reproductive health comes mainly from the mass media, friends, family members and health facilities. Many adolescent migrants lack basic knowledge about STIs, reproductive tract infections (RTIs) and HIV/AIDs. When talking about HIV/AIDs, most adolescent migrants refer to it as “an incurable disease,” “suicide” and “waiting for the death”. Respondents lacked basic knowledge about HIV/AIDS and did not know the main prevention methods. Although some adolescent migrants knew a little about STIs and RTIs, they had no clear understanding of infection and preventive measures. In fact, some of them felt that these diseases are very common and are easily treated if people have money.

In recent years, STIs, RTIs and other reproductive diseases have increased rapidly in China. Health data show that a large number of migrants, especially those under 30 years, have contracted STIs, RTIs and other reproductive diseases. Although few adolescent migrants in this study reported that they had ever contracted these

diseases, they said that their friends or peers had done so. They regard these infectious diseases as common diseases, however, and to some extent neglect many risks associated with them.

Some unmarried female respondents reported that they had experienced unplanned pregnancy and abortion. Previous research has shown that most unmarried females, especially those who work in service industries, have premarital sex, and some of them are commercial sex workers who have no knowledge of safe sex. At the same time, a large proportion of these people have experienced unexpected pregnancy, abortion, and STIs or RTIs caused by risk behaviors.

STIs and RTIs have increased rapidly in China due to no clear perception of infection or of prevention methods.

Married female respondents mainly reported difficulties caused by delivery or contraceptive complications. These problems are more serious in this group.

Social Factors

When adolescent migrants move to Kunming, they live in a different community from their hometown, and their lives and reproductive health are influenced by a new social environment, its culture and customs, and social networks. Their reproductive health is also affected. Access to health information and services, as well as the quality of services is also different.

Community Location

Most migrants live in areas between the central city and the suburbs, and the characteristics of these areas are typically different with other areas. Like other cities in China, there have been great changes in Kunming over recent years. The new city districts extend considerably, and a large area of agricultural land has been occupied. However, some new districts are neglected because of faults in city planning. There is widespread private construction, and a lack of management and services in these areas, with poor living facilities and bad sanitation. Because of the household registration system, migrants face restrictions over jobs and many other aspects of their lives. Most of them come from poor rural areas, and their economic status is very low. Most migrants, therefore, choose to live in areas with low living costs when they move to Kunming.

Actually, these areas are isolated from other areas, to some extent, so that migrants live in communities that differ from other places elsewhere in the city. There are many social problems in these areas, and the frequency of drugs, prostitution, robbery and other crimes are very high. The majority of adolescent migrants think they lack security in the community where they live. Under such a disordered

environment, adolescent migrants are at risk of experiencing many threats, including those related to reproductive health.

Culture and Social Networks

There are great differences in the culture of urban and rural areas. In rural areas, and in especially poor ones, people have conservative views about sex because of the traditional culture and poor information. City residents, however, have more open views about sex. People have better access to information and are influenced by diverse cultures, so they have more opportunity to choose their lifestyle. When adolescents migrate to the city, they also are affected by city culture and customs.

The majority of adolescent migrants come to accept premarital sex and cohabitation and regard them as common behavior. On the other hand, they also think that premarital sex is prohibited and regarded as immoral by many rural people. This inherent contradiction exists because adolescent migrants are affected by two different cultures and customs, one rural and conservative and the other urban and more liberal. As a result, they sometimes express conflicting and inconsistent views about sexual behavior.

There is also a great difference in social networks between adolescent migrants' new communities and their hometowns. Compared with the city, social relationships are more closed in rural areas. In Chinese rural communities, social networks based on kinship are very powerful. Rural people keep closed relationships with their family and relatives. Adolescents' behaviors are supervised by their family and older relatives. To some extent, their attitudes and behaviors towards sexual relationships are restricted by this social network. When they move to the city, this relationship is weakened. In the new community, they develop new social networks, and they are influenced by their peers and others in their lives and social activities. Their new relationships are more open and less restricted. All types of views about sex and actual sexual behaviors are easily accepted and tolerated by the community. Even adolescent migrants living with their family members in cities have more freedom compared with those living in their rural hometowns.

Adolescent migrants are living with conflicting norms – conservative versus liberal – and under different social network controls, which can lead to conflicting and inconsistent views about sexual behaviors.

Influence of Families and Peers

Family and peers influence adolescent migrant motivations, choice of destination, living conditions, knowledge and actions regarding reproductive health, directly or indirectly. In traditional Chinese culture, the family is very important. In rural areas of China, the majority of youth end their education after graduation from junior

secondary school for personal or economic reasons. Most of them are forced to go out to look for jobs because of limited land and limited sources of income in their home towns. Because of the lack of alternative income sources in rural areas, it is family members or persons from the same village that become the main sources of information for young people who want to look for jobs outside, and that influence their choice of destination for migration. In addition, changes in relationships between family members, such as parents' divorce, re-marriage after divorce, sickness and death, are also important reasons for adolescent migration.

Most adolescent migrants live with family members or friends. Because migrant adolescents lack guarantees about living and working, family members and friends are usually the people who help them when they are in trouble. At the same time, adolescent migrants, especially those who do not live with family members, are influenced easily by their friends. They have many characteristics in common, such as smoking and drinking.

When adolescents move to cities, the influence of the familial network is weakened, while peers influence them more in their new environment.

Because of a lack of information and low education in rural areas, most adolescents know little about reproductive health. Family members and friends are the main sources of their limited knowledge. Young adolescents, especially female adolescents who live with family members, are influenced greatly by them. Female adolescents' initial knowledge about menstruation comes from their mothers or elder family members. When it comes to sex before marriage and cohabitation, they are cautious, since they are uncertain about their family's reaction. In this case, families exert social control over the sexual behaviors of adolescents.

Older adolescents living without family members are influenced greatly by friends. In the traditional culture of China, sex is a forbidden topic in the family. Neither sex before marriage nor cohabitation are permitted. But in a peer group made up with friends of similar ages and backgrounds, there are no obstacles to talking about these topics. Consequently, adolescent migrants' opinions about sex before marriage and cohabitation are usually influenced by their friends. In fact, in our study, some female adolescents living without family members admitted having premarital sexual relationships, unplanned pregnancies and abortions, as do their friends. But none of the female adolescents living with family members admitted having such experiences. Once again, the family constrained their sexual behaviors.

Migrants were also influenced by their friends when they choose places to receive reproductive health services. For example, female migrants usually followed the suggestion of friends who had similar experiences when they chose clinics to have an abortion.

Access to Information and Quality Services

Compared with their rural communities, adolescent migrants have greater access to information in their new urban environment. Adolescent migrants obtain information on reproductive health from the mass media (newspapers, magazines, television and radio). Some also obtain it from drug stores, clinics and hospitals. Their access to information at health facilities, however, usually happens while they seek medical services, as these health facilities seldom provide information to them voluntarily. But while they have access to more information about reproductive health in the city, this information is usually sporadic and incomplete. According to many health service providers, it is very important to provide knowledge about reproductive health to adolescent migrants. However, provision of information is still very limited at health facilities.

Although most adolescent migrants think that there is better medical technology and quality of service in Kunming compared with their home villages, they also complain about the higher medical costs and the more complicated procedures that must be followed in using health facilities.

In general, adolescent migrants can access three types of health facilities that provide reproductive services in Kunming: private facilities (clinics), public hospitals and family planning centers.

Usually, when adolescents first experience reproductive problems, they either buy drugs or do nothing. When their reproductive health problems become more severe, adolescent migrants usually resort to private health facilities. Traditionally, health facilities belong to the State in China, and private facilities have only developed in the past 10 years. The majority of private facilities are private clinics, which cause many problems because of their lack of management, their poor medical instruments, and their lack qualified service providers. It is very common for them to make incorrect or incomplete diagnoses or to cause complications for their patients. On the other hand, the majority of these clinics are located in communities where migrants live; they do not require registration; and they charge lower fees compared to public hospitals. Hence, many adolescent migrants choose them even though they know the risk.

If the reproductive health problem cannot be cured in private clinics or it becomes more complicated, adolescent migrants have no choice but to go to public hospitals. Public hospitals are located in the centre of the city and mainly provide services to city residents who have medical insurance. Public hospitals are the least affordable for adolescent migrants on low incomes, and many adolescent migrants feel that affordability is a major obstacle in accessing services. Yet public hospitals are able to provide better quality services because of their qualified staff and good medical equipment compared with private hospitals or clinics. However, these hospitals

cannot provide appropriate services to adolescent migrants with lower economic incomes because of the lack of the appropriate policies and the existence of complicated procedures. In addition, many public facilities are located in the center of the city, and it is difficult to serve suburban communities where the migrants live.

Compared private and public health facilities, family planning centers can possibly provide appropriate and reliable services to adolescent migrants. There are appropriate, government-supported family planning centers in the communities where the migrant live, these centers mainly serve migrants, and they are as convenient as private clinics. They are also non-profit, so they are more economically suitable for adolescent migrants. However, according to the management rules about family planning for migrants made by the State Department in 1998, family planning services are confined to married women of reproductive age. Unmarried migrants, therefore, cannot access family planning services unless they are pregnant. In addition, married male migrants are excluded from seeking reproductive services from family planning centers. In addition, adolescents are required to register when they seek services from these centers, which discourages some adolescent migrants from obtaining services.

Unmarried adolescent migrants and married male migrants are excluded from seeking reproductive health services from family planning centers.

The type and quality of health services are not the only obstacles that block migrants from accessing quality reproductive health services. As a marginal group, adolescent migrants face many cultural and psychological barriers that block their access to health services, and reproductive health services especially. Because they are not a part of the urban mainstream society and its benefits, which is reinforced by their exclusion from the resident/household registration system, they are very apprehensive about seeking services. If they have a reproductive health problem, such as an STI or even suspect an unplanned pregnancy, they fear being blamed by other people for violating social norms. In particular, they feel embarrassed to see a doctor or other health service provider because they fear being stigmatized or ridiculed. Consequently, they do not seek service in time, which makes their illness more serious.

Access to public RH services is hindered by economic and psychological barriers.

On their part, service providers feel that there are communication obstacles and a sense of distrust between themselves and adolescent migrants. *When adolescent migrants seek services, they often disguise the real cause of the disease, and even have conflict with service workers, which increases the difficulty of serving them.* At the same time, many health service workers can provide only basic medical treatment to adolescent migrants, and they cannot offer them appropriate counseling. Hence, adolescent migrants' reproductive health problems are difficult to treat.

Nonetheless, many health workers feel that it is very important that professional health workers become involved in providing reproductive services to adolescent migrants and publicizing these services throughout in the community.

In the view of service providers, there are communication obstacles and distrust between service providers and adolescent migrants.

CONCLUSION

Migrants as a Marginal Group

Adolescent migrants are a marginal group. They are kept out of mainstream society and deprived of its benefits, including not being covered by the major social and medical insurance schemes provided by the government. In addition, some female migrants are involved in the commercial sex industry, and they share the same social networks with other migrants. As a result, the migrants are enclosed in a relatively isolated community with high reproductive health risks.

Adolescent migrants are different from local patients. Due to their low economic status and the psychological barriers that keep them emotionally apart from mainstream society, it should be the responsibility of health service facilities to provide them with quality services. But this is no easy challenge. Migrants have a limited ability to pay service costs because of their lower incomes. At the same time, they have to pay more for medical costs than urban residents because they are not covered by medical insurance. In addition to being economically disadvantaged, as a marginal group adolescent migrants must face many cultural and psychological barriers when they seek health services. As noted above, *most adolescent migrants think that they will be blamed or stigmatized by other people, including health service providers, which places them under a high level of stress when they have reproductive health problems. Under that burden, an adolescent migrant is reluctant to seek services in time, which can cause their condition to become more serious, and, in certain cases, may place others at risk if their condition is contagious.* Increasing the abilities of adolescent migrants to access low-cost services, while also improving the interpersonal communication skills of health service personnel could go a long way in preventing reproductive health threats among this population group and others.

Two Groups Need More Attention

Since they are a marginal group, little is known about adolescent migrants' reproductive health status. Our study mainly focused on the individual and social factors affecting adolescent migrants' reproductive health and needs in Kunming, Yunnan. Different migrants who are living under different conditions in other cities and regions may face different reproductive problems and risks, and research is required to uncover their nature.

In addition, analysis of the data in our study suggests that two migrant groups should receive particular attention: unmarried migrants, especially women and those living separately from their families, and married men.

Compared to men, women face much greater physical and cultural effects from reproductive problems, and they also have more restrictions. In addition, this group lacks knowledge about reproductive health. They do not know basic contraceptive methods, and they have limited access to reproductive information. When they have reproductive problems, they face psychological and economic constraints in the process of seeking services. There is also a lack of appropriate and effective services provided by health facilities for them. Although few unmarried female migrants reported reproductive problems or diseases in our investigation, our study did find that a large number of unmarried female migrants have experienced abortions or other reproductive problems. *This group urgently needs appropriate information and services.*

Two groups of migrants need particular attention: unmarried female migrants and married men.

Married men is a special group among adolescent migrants, and they are often neglected in reproductive health research and programming. Compared with married females, married males have a higher status in terms of social values and culture, and their rights are stressed and accepted with regard to sexual relationships. Unfortunately, this also puts them at greater risk of reproductive problems. Investigations show that there is a higher probability of risk behaviors for married men than women, which places not only the men at risk of reproductive threats, such as STIs and HIV/AIDS, but also their wives and children. Information about reproductive health should be disseminated to them and their spouses, especially knowledge about risk behaviors that cause STIs and HIV/AIDS and effective means of prevention.

Married men is a special group among adolescent migrants, and they are often neglected in reproductive health research and programming.

Although these two groups should receive particular attention, the reproductive health status and needs of other migrants cannot be neglected. It is important to consider unmarried males' need for knowledge about reproductive health, and married females' need for quality reproductive health services.

In conclusion, it is very difficult to obtain accurate information about adolescent migrants' reproductive health status because of their marginal lives and the sensitivity of the topic. Unlike previous research, only a few respondents in our research reported reproductive problems or diseases. However, the research also shows that a large number of migrants are affected by reproductive health infections,

and they lack information. Several actions must be undertaken to begin addressing the needs of this significant population group.

Recommendations

1. Dissemination of gender-sensitive reproductive health knowledge and training activities aimed at preventing reproductive health threats should be conducted among adolescent migrants of all ages.
2. Training programs should be organized to strengthen the capacity of service providers in working in local communities and in communicating effectively, and compassionately, with adolescent migrants and young people, in general.
3. Reproductive health education should be provided to adolescents in their communities of origin *before* they migrate to urban centers as well as their communities of destination.
4. Community-based reproductive health service centers should be established so that they are readily accessible to adolescent migrants and available to all migrants, be they married or unmarried, women or men.
5. Local community-based organizations should be developed for migrants, managed by migrants, and serve migrants in order to improve their quality of life and protect their reproductive health.

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Adolescent Migrants and Reproductive Health in Lao PDR: Concern for the reach of reproductive health information and services

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INTRODUCTION

In Lao PDR, evidence shows that many adolescents move to work in cities, but they are not likely to access sexual and reproductive health information and services. Currently, the number of adolescents is increasing which, in turn, produces greater demands for social and health services (National Statistic Survey, 1995). The Laotian government is aware of the problems faced by youth. Knowledge of Laotian adolescents on reproductive health, particularly on contraceptives and safe sex, is very limited and access to services is minimal. Adolescent reproductive health problems include an increasing prevalence of teenage pregnancies and induced abortion, the spread of STIs and HIV/AIDS, and the use of illegal drugs. Greater awareness and concern about the effects of modernization and its socio-economic changes on the Laotian population has led the government to commit more resources to youth programs (Reproductive Health Survey, 2000).

OBJECTIVES

To better understand the reproductive health situation of young people in Laos, this study's main objective was to assess the knowledge and attitudes towards reproductive health as well as the utilization of reproductive health services among adolescent migrants in Vientiane City, Lao PDR. The study's specific objectives were:

1. To identify reproductive health risk behaviors leading to unwanted pregnancy, STIs, and reproductive tract morbidity among adolescent migrants;
2. To identify barriers to accessing information on reproductive health among adolescent migrants; and
3. To explore the utilization of reproductive health services among adolescent migrants.

PREVIOUS STUDIES

Most adolescent reproductive health studies conducted in Lao PDR have focused on rural and urban youth as well as some specific groups, such as service women and out-of-school youth (WHO, 2005). The Lao People's Revolutionary Youth Union, in collaboration with the Lao National Statistical Centre, the Japanese Organization for International Cooperation in Family Planning and the United Nations Population Fund (UNFPA) conducted an Adolescent Reproductive Health Survey (ARHS) in 1999. Its objective was to identify adolescents' reproductive health knowledge and behaviors, including sources of information and the services utilized by adolescents. The results indicated that fifty-percent of the young people aged 15-25 years had experienced sexual intercourse, while the other half considered pre-marital sex as unacceptable. Over half of the young people had heard of contraceptive methods. Of these, the condom was the most well-known. Nearly half of the young people knew that condom use can prevent pregnancy, and 76 percent knew that induced abortion is dangerous. The major sources of information on contraceptive methods were friends, television and radio. Survey results also showed that 50 percent of respondents had heard of STIs, and three-quarters knew about HIV/AIDS.

This study, like most others, concentrated on adolescents in general, and not specifically on adolescent migrants. Consequently, specific knowledge of adolescent migrants and reproductive health is needed to understand their lives as well as their sexual and reproductive health in order to formulate and implement specific policies and targeted programs.

METHODOLOGY

This study was conducted in Vientiane, the capital city of Laos. Four out of nine urban districts were purposively selected, namely, Chanthabury, Sikhottabong, Sisattanak and Xaysettha districts, as these contain large populations of adolescent migrants.

In-depth interviews were conducted to collect qualitative data among adolescent migrants and reproductive health service providers working at a major hospital and a selected district hospital. In total, 58 adolescent migrants (27 females and 31 males) were recruited from household listings provided by village headmen. The respondents consisted of adolescent migrants aged 15-24 who:

- had been living in Vientiane Capital for more than three months;
- married or unmarried; and
- living with or without their families.

In addition, 16 reproductive health service providers were selected to obtain information and elicit their perspectives on adolescent migrants and reproductive health. All in-depth interviews were tape recorded with the consent of respondents and then transcribed for data analysis.

RESULTS

Characteristics of Adolescent Migrants

The mean age of male and female respondents in this study was virtually the same as shown below (Table 1). Overall, female adolescent migrants were aged between 16 to 24 years, whilst the ages of male adolescent migrants ranged between 15 to 24 years. The majority were from either the southern or northern areas of Laos. In the northern area, the majority were from Houaphanh and Luangprabang provinces, as well as some from Xiengkhouang, Sayabury and Louangnamtha provinces. For those from the southern area, their home communities were in the provinces of Champasack, Savannakhet, Khammouane and Bolikhamsay. Most of the adolescent migrants were workers or students; a relatively few were street vendors or had other occupations.

Table 1. Socio-demographic characteristics of adolescent migrants in Vietnam

	Mean age	Residence in Laos before migration			Occupation			
		North	Central	South	Worker	Street vendor	Student	Other
Male	21.5	10	9	12	14	1	10	4
Female	21.2	10	7	10	14	6	9	
Total		20	16	22	28	7	19	4

Reasons for Migration

The findings regarding the pull and push factors for migration were similar among both male and female adolescent migrants. The majority of respondents reported that they moved to the city to work or to study. Their related reasons for migrating were to be able to choose a job in a “civilized” town, to escape from boring work in the rice fields, and to earn a higher income. In addition, they would have a chance to study English and to continue their education so they would be able to get better, higher-paying jobs. They also wanted to be exposed to an urban environment in order to improve their knowledge and life. Moreover, in their rural communities, poverty is common; electricity and water supplies do not exist; and no opportunities are available for higher education or well-paid work. Some migrants also experienced family and community problems, such as theft, drug addiction, and peer pressure. Not all of the migrants moved alone. Some followed other family members, and some moved to stay with relatives who were already living in Vientiane.

Female migrants (married and unmarried) are more likely to migrate to work in the city than male migrants. These female adolescents mentioned that at home, there are no opportunities to earn money and no work for women; there is only work in the rice field. Some female migrants reported that they are responsible for caring for their parents, other family members, and siblings. They cannot earn enough money in their rural homes to provide this care, so they migrated to Vientiane to earn a higher income. They had heard from friends living in Vientiane that they could make good money working in factories. Hence, the need to support their families, lack of income-generating activities at home, and the likelihood of earning money in the city drove their desire to migrate.

Female migrants are more likely to migrate to the city than male migrants due to limited work for women in rural areas.

Life in Vientiane

Before moving to Vientiane, the adolescent migrants imagined the city as being a civilized place that could provide them with many things that they felt they needed. It would be a good place to get a higher education and to work. They would be able to choose whatever job they liked, and they could send money back to their parents. This would help themselves and their families to escape poverty and to improve their lives in their home communities.

After moving to Vientiane, they realized that only a part of what they imagined was actually true. Indeed, Vientiane is more developed than their rural communities. It is more convenient to travel and to communicate with others. However, they also realized that living in the big city can be extremely difficult and not as pleasant as they previously thought. They reported many problems. Rather than being a source of income, working in the city is hard if one does not have enough money. In addition, making money is not as easy as they thought. Most significantly, the cost of living in the big city is more than the money they earn, which is not sufficient to cover their daily living expenses. They also have difficulties with transportation and accommodations.

Other aspects that are different from their rural homes is that the city is crowded, polluted and noisy. They also reported that the lifestyle in a big city is unorganized and people are not friendly.

Living in Vientiane is different from what I thought. The good points are that there are more places to work and to earn money than my old home, which I can use to pay for my business management course. However, it is not easy to get a job, and I have to spend a lot of money just living. I must think carefully before spending money on something. Here, I have to rent a house and buy rice to eat. (Married female migrant, aged 22, from Sisattanak district; she is living with her husband.)

When living in a big city like Vientiane, adolescent migrants are faced with many expenses, such as the need to rent a house and to pay for food, transportation, education materials, medicine when they become sick, electricity and water. Thus, living expenses are very high, and the migrants usually do not have enough money. Another problem is making money. The migrants in this study are not well educated and are not qualified for adequately paying jobs. Therefore, they cannot earn as much money as they expected, and they must work very hard just to survive. All of them have had to find alternative ways of making a living, such as selling clothes, raising ducks and chickens, or gardening. Whenever they needed advice or support, they turned to their relatives, many of whom were also in, or had experienced, the hardship of city life.

Life in the city is not easy, and most migrants must find multiple ways of earning money to survive, many of which were not available to them in their home communities.

Family Bonds

When asked whether the adolescent migrants miss their old homes while living in Vientiane, most said that they do miss their parents and siblings.

I miss my own home, parents and family. My family is poor; we don't have money to buy food for my child. I don't want to go back to my old home. I just visit my child and my wife occasionally. (Married male, aged 24, from Sikhot district; he is not living with his wife.)

Most of the migrants reported strong ties with their families of origin in rural areas. Their aging parents and their siblings are left behind, still working hard in the rice field. Consequently, the adolescents put all of their efforts into surviving, helping themselves in the city, and sending remittances back home. When they are in a better financial situation, some of them want to bring their families to live with them in the city.

Though facing difficulties living in the city, they have no intention of going back to their hometowns. They would only go back if there are no more jobs available in the city, or they have been assigned by the government. Otherwise, they will only return to their rural homes when they have the chance and it is convenient.

Although the migrants are facing a hard life in the city, they are still able to send money back home. Financial support thus flows from the adolescent migrants back to their homes in rural areas, and not vice versa.

Reproductive Health Behaviors and Risks

Personal Behaviors

The majority of respondents know how to take care of themselves, and they exercise when they have the time. Male migrants drink liquor with friends on some occasions, such as on special days, on weekends or pay days.

Adolescent migrants have less time and money for entertainment that would expose them to RH risks.

I drink liquor about twice a week with friends when I visit them. (Married male migrant, aged 24, from Saysettha district; he does not live with his wife.)

Usually, female migrants do not drink or smoke. In Lao society, girls do not have a habit of smoking, while some male migrants smoke around 4-10 cigarettes per day. Young migrants also do not have much free time, and they have few chances to relax, such as listening to music, watching television, or visiting their relatives. When they do have free time, male migrants like to play the guitar or sing, go fishing, or court a girl. Results of this study show that young migrants must work hard in order to earn money. Consequently, they have little time for activities that would expose them to reproductive health risks. Moreover, after sending money back home, there is little left for them to spend on entertainment.

In my free time, I need to study, but I really don't have free time because I have to sell clothes and then go to school. I'm tired and need to sleep. (Unmarried female migrant, aged 20, Chanthabury district.)

Sexual Norms

When asked about sexual relationships, the majority of respondents preferred that men and women be honest and faithful to each other. According to Lao culture, a sexual relationship should develop after marriage. Young girls, in particular, should remain virgins and avoid premarital sex. The majority of young men preferred women who were virgins to be their spouses. However, there were some who considered only love as important, and it did not matter if a woman was a virgin or not.

"If I marry a woman, she must be a virgin and a good woman in Lao society. (Unmarried male migrant, aged 22, Chanthabury district)

On their part, although young women also preferred to find young men who had had no sexual relationships with other women before a marriage, it was difficult for them to find such men. Urban life and peer pressure encourage young men to have sexual relationships before marriage.

When living together, adolescents are more likely to give advice to each other, especially when they are curious. When asked about premarital sex, the majority of the adolescents did not accept it, which is in line with Laotian tradition and morality. Similarly, a previous study found that over half of young people considered that sex before marriage was not acceptable (Lao People's Revolutionary Youth Union/ JOICEP /UNFPA, 2000). Laotian culture condemns premarital sexual relations. A couple who has premarital sex will be considered bad people in society. However, some conditions encourage this behavior. Currently, Laotian society is changing, and a large gap exists between urban areas, with their nightclubs and bars, and traditional Laotian rural life. Some adolescent migrants realize that premarital sex often happens in the city, unlike rural areas, and it may be considered normal.

I do accept that it is normal that a man and a woman have premarital sex because they are lovers. We need to have a deep relationship in order to keep our faithful love and finally we can marry. (Unmarried male migrant, aged 23, from Xaysettha district.)

In urban areas, it [premarital sex] may be considered as normal, but we cannot accept it in rural areas because we believe that we need to get married first. (Unmarried female migrant, aged 20, from Chanthabury district.)

Opinions on Equal Rights

Gender issues are currently a big subject of discussion in Laos. Although males and females have equal rights in society, their rights are not equal regarding their degree of sexual freedom. Currently, unmarried and married men are freer to have premarital and extra-marital relationships than women. Married men can also have sexual relationships with minor wives.

Among women, those who are unmarried have more freedom than those who are married. The prevailing gender norm is that married women are responsible for their families and should respect to their husbands, a belief that is often echoed by elderly persons on wedding days. According to Lao tradition, the blessing given to the married couple is usually “to have one wife and one husband and respect each other forever.” Married women must be honest and be faithful to their husbands. Unlike their husbands, they have no right to have extra-marital sexual relationships. Some of respondents said that only single women have equal rights regarding sexual matters.

Unmarried women have more freedom than married women with regard to sexual relationships.

I think they should not have equal rights. Single women should have equal rights, but married women should not. For example, a married man can have

another wife, but a married woman cannot. If she does, it is not acceptable in our society, and people will talk behind her back. (Unmarried male migrant, aged 23, Chanthabury district)

Prevention of Pregnancy

In terms of preventing pregnancy before marriage, the majority of respondents reported that both men and women should be responsible in this matter. However, a woman plays a more important role, since she is the one who carries the pregnancy. Similar to the ARHS study in 1999, over half of the adolescent migrants felt that pregnancy out of wedlock is not socially acceptable. Male adolescents also know that condom and contraceptive pill use will prevent women from becoming pregnant. In addition, women should also know about a safe period of their menstruation cycle.

Women should be responsible for preventing themselves from pregnancy. They should use contraceptive methods and should not have sex before getting married. They should wait until everything is ready before getting pregnant. (Unmarried female migrant, aged 21, from Chanthabury district)

The migrants interviewed in this study are familiar with different kinds of contraceptive methods, such as condoms, pills or injections, the safe period and withdrawal. Yet, most of the migrants admit that they do not use any form of contraception, since they want to have a baby. For those who have only one child, especially, they want to have a second child. Among those who use contraceptives, condoms are the most common, followed by pills and the safe period.

Prevention of STIs and HIV/AIDS

Almost all of the respondents know very well about AIDS and STIs as well as ways to prevent them and their transmission to others. They noted especially that they must be careful to take care of their health and prevent themselves from diseases that will shorten their lives. The majority of respondents believe that AIDS is a very severe disease and cannot be cured. The best way to avoid contracting and transmitting this disease to other people is for men to avoid having sex with multiple partners, especially commercial sex workers. They also noted that men should have only one wife and be faithful to her.

Men and women are considered equally responsible for AIDS prevention.

Men should be responsible for preventing themselves from contracting AIDS, because AIDS cannot be cured and we will only wait for death. Our society will not accept people who contract AIDS, and friends will also stay away from them. Men should use condoms when having sex to prevent contracting AIDS. (Unmarried male migrant, aged 23, from Xaysettha district)

Moreover, the adolescent migrants also felt that women should also be responsible for preventing themselves from contracting HIV/AIDS and STIs. They should follow prevailing norms and not have premarital or extra-marital sexual relations, which will also conserve their own dignity.

Reproductive Health Information and Services

Sources and Type of Information

The majority of respondents reported that they received reproductive health information from the mass media (i.e., TV, radio and newspapers), as well as family and community members, including village authorities and drug sellers, school authorities and health education teams. The main source of information, however, came from friends. The information they received was related to family planning, menstruation, pregnancy, child delivery and abortion. They also have heard about STIs (i.e., gonorrhea, leucorrhea and syphilis) and HIV/AIDs. Some migrants reported that they had received this information in their home communities but not in detail.

I have heard more information from television while living in the city than when living at my rural home. For instance, we should treat gonorrhea and use condoms to prevent contracting it, which I did not know when living at home. (Married female migrant, aged 21, from Sikhotabong district)

Overall, adolescent migrants are more knowledgeable about family planning and HIV/AIDS than STIs. Male adolescents are very familiar with AIDS and gonorrhea. On the other hand, female adolescents are more likely to get reproductive health information than male adolescents. Female adolescents know about menstruation, pregnancy, delivery, abortion, leucorrhea and family planning in addition to AIDS and gonorrhea.

Male adolescent migrants know more about STIs and AIDS, while female migrants are more likely to get RH information.

Health and Reproductive Health Services

In this study, most adolescent migrants are healthy, while a few suffer from health problems, such as coughs and colds, sore throat, fever, headache and dizziness, chest pain, rheumatism, heart problems, ear pain, nevralgy, liver problem, appendicetomia, asthma, parasitis, stomachache and dental problems.

Most of the adolescent migrants felt that compared to their rural communities, Vientiane is better-equipped to provide them with health services. This city has several large hospitals with modern equipment and medicines, X-ray rooms and operating rooms. In addition, there are many experienced doctors who provide

timely care for their clients. The adolescent migrants also noted that they have many choices in terms of health service facilities, not just large hospitals but also private clinics and drug stores. However, they noted that for large hospitals where there are many clients, they need to wait in a queue for a long time before seeing the doctor. Many become bored and disheartened. Nonetheless, the quality of treatment is better than they could receive at home. It is also much more convenient. If they had a severe health problem in their rural communities, they might have to travel days before getting to the nearest health facility.

Adolescent migrants in this study have limited knowledge about and access to reproductive health services, and they do not actively seek out information on reproductive health.

When they do seek out reproductive health services, some adolescents admitted that they are shy and do not want anyone to know their problems. Other obstacles are that they do not have their own transportation, they do not know where to go, and they have no one to accompany them to the health facility. Oftentimes, both male and female adolescent migrants prefer to go in pairs when seeking reproductive health services. They prefer to have friends or relatives accompany them, which reduces their anxiety and fear. They have someone to talk to, to discuss the situation, to ask for advice, and to provide urgent assistance, if needed.

Adolescents have limited knowledge about and access to RH information and services.

Obstacles in accessing health facilities include transportation, the need for companionship, and cost.

Money also plays an important role, since it is another barrier that can potentially block adolescent migrants from accessing health services. In most cases, however, respondents reported that they did not pay much for health services, since they suffer from only minor health problems. Most of the adolescents paid between 50,000 kip and 100,000 kip (5-10\$US) for medicine and for ultrasound. The cost of services varies according to the severity of illness. In the case of hospitalization or the need for an operation, the cost can be more than 1,000,000 kip (100\$US). Health insurance coverage in Laos is still limited and restricted largely to those working in business and the wealthy. The majority of adolescent migrants in this study are not covered by insurance. Only a very few who work at factories and companies have health insurance.

The majority of adolescent migrants interviewed in this study were not affected by reproductive health problems. Some, however, have experienced pelvic pain during menstruation, irregular menstruation and leucorrhea, pregnancy complications, abortion and RTIs. They also know of friends with gonorrhea. They reported that they deal with these reproductive health problems by seeking treatment at a drug

shop or pharmacy near where they live, since it is easier and convenient. Sometimes, neighbors provide them with advice.

In emergency cases, some migrants prefer to go to private clinics where they received quick service. They use a public hospital only if it is nearby, inexpensive, and if they knew someone who worked there.

Drug stores and private clinics are the main sources of RH services for adolescent migrants due to convenience.

The majority of my friends go to a drug store or clinic which is easier and they received good service. (Unmarried female migrant, aged 22, from Sisattanak district)

Opinions on the Consequences of an Individual's Reproductive Health Behavior

In the eyes of adolescent migrants, the consequences of a woman becoming pregnant out of wedlock are dire. Premarital sex leading to an unplanned pregnancy brings about shame and social condemnation in Lao society. The women will become depressed, and some may consider suicide if the fathers will not acknowledge responsibility for the pregnancies. If a woman decides to keep her baby, she cannot work as usual and will have greater financial difficulties. The adolescent migrants felt that the best way of dealing with this situation is for the woman to terminate the pregnancy, though they did not know about the complications that this could entail. Consequently, adolescent migrants are at great risk in this regard. Yet, some respondents felt that the woman should continue her pregnancy and marry the father of the unborn child, if possible.

It depends on the situation. If she cannot afford to have a baby, she should terminate her pregnancy. On the other hand, if the father of the unborn child will be responsible for it, she should keep her baby. (Unmarried female migrant, aged 20, from Chanthabury district)

For a married woman, however, this situation is not a problem. Respondents noted that she needs to discuss with her husband or consult a doctor about how to prevent pregnancy.

In Laos, abortion is illegal, except when a woman has health problems related to the pregnancy. In this case, a woman can consult with a doctor at a public health facility and receive a therapeutic abortion, if necessary. For unwanted pregnancies, abortions are usually conducted outside the formal health sector. Women who have undergone an abortion, however, can seek care at public health services when faced with the complications of abortion.

Perspectives of Health Service Providers

Providers at Health Facilities

According to health service providers, a health facility has no defined catchment area or specific number of patients for which to provide care. The general population, as well as adolescent migrants, can come for services at any time, and especially for emergency cases. Most service providers reported that they have provided care to male and female adolescent migrant workers aged 17-25 years. Females usually come for gynecological exams, and males come to the outpatient unit for health care. Based on their accent, these workers mainly come from the Northern and Southern parts of Laos, which is consistent with the results received from adolescent respondents. The majority of these migrants were female workers who work in sewing factories or factories that produce shoes or dolls. Some work for mattress companies or in bars. Most of them live in a company dormitory or with friends. The health service providers noted that reproductive health services are provided for all people rather than specific groups. They felt that adolescents will not come for services if specific services are organized for them.

We don't want to organize services for a specific group, especially for adolescents, because they are shy and will not come for reproductive health services. (Health staff at Setthathirat hospital)

Health facilities provide several different types of reproductive health services including gynecology/obstetrics, STIs/HIV/AIDS, maternal and child care, antenatal care, and birth spacing (i.e., pills, injection, sterilization, IUD insertion and condoms). A hospital-based birth spacing program started in 1993, and an STI/HIV/AIDS program in 1999/1997. In addition, a premarital counseling project was initiated in 2000 to provide premarital counseling to couples on important reproductive health issues, including pregnancy, family planning and the prevention of STIs and HIV/AIDS.

The major RH problems of adolescents, as reported by service providers, were irregular menstruation, unwanted pregnancy, induced abortion, STIs, leucorrhea and gonorrhea.

Adolescents are facing many reproductive health problems. As reported by health service providers, the major ones are irregular menstruation, unwanted pregnancy, induced abortion, STIs, leucorrhea and gonorrhea.

Female adolescents worry about irregular menstruation. Some of them come for help in dealing with the complications of abortion or to seek help in terminating an unwanted pregnancy. Male adolescents came for advice on urinary tract infections or they thought that they have contracted AIDS. (Health staff at Setthathirat hospital)

Health Staff at Youth Clinics

These service providers reported that adolescent migrants do not know how to access reproductive health services. They also lack information and knowledge on the prevention of reproductive health risks, such as preventing unwanted pregnancies, the complications of induced abortion, and STIs/HIV/AIDS.

According to the service providers, *there is a need to expand reproductive health information to reach adolescents by using educational materials through different channels, especially television and radio.* A health education campaign is also necessary at secondary schools, villages, dormitories, and factories or companies in order to improve adolescent migrant knowledge on reproductive health and increase accessibility to health services.

CONCLUSION AND RECOMMENDATIONS

The major factors leading adolescents to migrate away from their rural communities and into large cities, like Vientiane, are their desire to escape from poverty, the chance for higher educational opportunities, better job opportunities, and the freedom to explore and choose new lifestyles. These more modern lifestyles are different from what they have left in their traditional rural communities.

Yet, with their limited knowledge and education, their job opportunities are limited as well, and they must work hard to survive as well as to support their families back home. Free time is a luxury that many do not have. Some are fortunate enough to have strong social networks to fall back on, such as siblings or other relatives who also live in the big city, and who they can seek advice from as they sustain their lives in the big city. Having decided to move in Vientiane, the majority of adolescent migrants are not disheartened; they prefer to stay and live there forever. They will go back to visit their rural homes occasionally when it is necessary.

Their plight is further complicated by a lack of knowledge about reproductive health risks and their prevention. Knowledge about birth spacing, the means of contracting STIs/HIV/AIDS and their mode of transmission is still poor. There is a degree of social protection, however, in that premarital sex remains unacceptable to many, and especially among female migrants. The strong belief is that unmarried women should remain virgins and avoid premarital sexual relationships. But despite this belief, unwanted pregnancies, induced abortions and STIs exist due, in part, to limited accessibility to reproductive health information and services. Such information is gained informally through friends and the mass media. Because of a lack of accessibility to health services, moreover, the actual magnitude of reproductive health problems is unknown, as many go unreported.

To begin addressing the plight of adolescent migrants, and help them live more productive lives in their new urban environment, several actions are worthy of consideration, such as:

1. Increasing the access of adolescents—migrants and non-migrants, women and men—to accurate and up-to-date reproductive health information using channels that most appeal to adolescents, such as the mass media and its personalities (e.g., DJs, television celebrities, singers);
2. Conducting targeted IEC campaigns on reproductive health, on safe sex and the prevention of unwanted pregnancies, on the complications of abortions, and on the prevention of STIs/HIV/AIDS for adolescent migrants, especially those working in factories or companies and those living in dormitory facilities;
3. Expanding reproductive health services to more fully reach adolescent migrants and to encourage them to seek assistance as early as possible, such as organizing mobile clinics to provide RH information and services for all adolescents (including adolescent migrants); and
4. Strengthening existing policies and program strategies on reproductive health for adolescents, in general, and adolescent migrants, especially.

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Adolescent Migrants and Reproductive Health in Thailand: The importance of confidentiality and privacy at health facilities

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INTRODUCTION

In Thailand today, rural adolescents are prone to migrate to large urban areas in search of work, despite the difficulties they face in adapting to the new socio-cultural environment that they encounter. Moreover, due to a low perception of risk as well as limited access to and use of information and services, they are increasingly vulnerable to contracting and transmitting STIs including HIV/AIDS. They are also poorly informed about how to protect themselves from unwanted pregnancies, about the dangers of unsafe abortion, as well as about the challenges of young motherhood and its affects on their future. They also represent the group that is being largely ignored by existing reproductive health services that mainly cater to married women.

To shed greater light on this situation and to contribute to improving reproductive health services for adolescent migrants in Thailand, this study sought to:

1. identify adolescent migrants' risk of practicing unsafe sex leading to unwanted pregnancy, sexually transmitted infections and reproductive tract morbidity;
2. identify barriers to their access to information on reproductive health; and
3. evaluate their access to reproductive health services.

PREVIOUS STUDIES

Studies specifically on the reproductive health of adolescent migrants in Thailand are very limited. Most prior research has focused on in-school youth and some specific groups, such as factory workers and commercial sex workers. However, evidence from young factory workers can be applied to adolescent migrants because most of them are migrants from rural villages.

A survey of 539 female workers in a suburb of Bangkok revealed that over half of the women knew about sexuality and could explain about how to prevent STIs. As would be expected, married women had better knowledge than unmarried women

(Kaewboonchu et al., 1993). Nonetheless, a multi-method study on the sexual culture of factory workers in Bangkok and surrounding provinces uncovered a very low level of condom use within premarital sexual relationships (Ford and Kitthisuksathit, 1996). There was also a strong belief among the adolescents that condoms should only be used with commercial sex workers.

This low level of condom use during premarital sexual encounters is startling, especially considering the frequency of these relationships. A study conducted among school adolescents and factory adolescent workers indicated that about half of factory workers had experienced premarital sex. Their partners were those working outside of the factories or nearby, and with whom they typically met at a discotheque or karaoke bar. They generally began seeing their partners when they were 18-20 years old, and they expected to be married at 20-24 years of age. Women tended to have longer sexual relationships with their partners than men and with one partner at a time. By contrast, men had multiple partners and were involved in short- or long-term relationships (Department of Mental Health, 2004).

Though research into reproductive health needs and problems of adolescent migrants is rare, many research findings show that Thai adolescents, in general, have limited knowledge about sexual and reproductive health, and they are practicing unsafe sex. Ford and Kitthisuksathit's study (1996) on the health-seeking behavior of factory workers showed that female workers discussed sexual and reproductive health issues with their friends, followed by their mothers, and lastly health care personnel. The use of health care services, moreover, was complicated and stigmatized adolescents who came with reproductive health problems (e.g., unwanted pregnancies, STIs, HIV/AIDS and menstruation).

This finding about the quality of reproductive health services and its implications for access by adolescent migrants has been echoed in other studies. For instance, a survey was also conducted among health personnel in government and private clinics regarding the types of services adolescent patients used within one week. Results showed that adolescents are more likely to use reproductive health services for STIs, RTIs and pregnancy tests at private clinics and private hospitals more than at government health centers (Boonmongkon, 2000). Adolescents hold negative views about government hospitals, largely because of the lack of privacy, inconvenience, long waiting time and the lack of attention provided by health workers. Adolescents preferred to go to sub-district health centers because the service providers there paid more attention to their patients, and they were friendlier in dealing with them. They also felt that drugstores were a source of advice, and they were convenient locations for buying inexpensive medicines, though the advice and prescriptions might not be accurate (Boonmongkon, 2000).

METHODOLOGY

This study was conducted in four major study sites in Bangkok where adolescent migrants usually cluster, namely: 1) slum areas, 2) factory neighborhoods, 3) construction sites, and 4) dormitory housing areas.

Qualitative research methods were used to gain an in-depth understanding of adolescent migrants and their reproductive health situation. These methods included in-depth interviews using an interview guide and non-participant observation. Data were collected by four interviewers who were given an orientation on the study's objectives and who were trained in collecting qualitative data using the study's data collection tools.

The study was conducted among both adolescent migrants and health service providers during May - September 2002. The 65 adolescent migrants in this study comprised six distinct groups:

1. unmarried male adolescents (15-24 yrs.) living with relatives
2. unmarried female adolescents (15-24 yrs.) living with relatives;
3. unmarried male adolescents (15-24 yrs.) living alone or with friends;
4. unmarried female adolescents (15-24 yrs.) living alone or with friends;
5. married male adolescents (15-24 yrs.) living with their spouses; and
6. married female adolescents (15-24 yrs.) living with their spouses.

All of the migrants had been living in Bangkok and its vicinity for at least three months but no longer than three years.

In addition, 21 health service providers (physicians, nurses) working in public hospitals and health centers also participated in the study. These providers were identified by the migrants during interviews, and they were interviewed in order to:

1. understand the reproductive health situation of adolescent migrants, such as their reproductive health problems, experiences, and needs;
2. examine the health facilities provided for adolescents, and adolescent migrants in particular; and
3. cross-check as well as supplement data obtained from the adolescent migrants.

The health service providers worked in 16 health service facilities. They were sent letters (including the interview guideline) asking permission from Hospital Directors, Heads of Provincial Health Offices, or the Bangkok Metropolitan Area (BMA) Bureau of Health for their participation. Committees then considered the study's proposal and interview guideline. It took about one year to collect data from this group because of the bureaucratic system and its regulations. In addition, although adolescent migrants reported that they also used private hospitals, this study could not collect data from private hospitals because they said that "*They did not have data on the target group (15-24 years), and it was very difficult to find the target group.*" Consequently, ten public hospitals and six health centers were selected.

For both the adolescents and health providers, an in-depth interview guide was prepared and pre-tested. A consent form was used for each in-depth interview. Information from in-depth interviews was transcribed and analyzed using several forms of content analysis, including successive approximation, analytic comparison, and cultural analysis to construct the safeguards and risk behaviours of migrants including their reproductive health problems and health service utilization.

RESULTS

Reasons for Migration

This study included unmarried and married male and female adolescent migrants. All of the adolescents shared similar reasons for migration, which cover both push and pull factors as noted below. The major force that led the adolescents to migrate was their desire to escape from poverty through better work opportunities or education in large urban areas. By leaving their families of origin, they also reduced the number of household dependents, thus relieving their families of the additional burden of support. Moreover, the remittances that the migrants send back to their families also reduce this burden even further by increasing family income.

By migrating to cities, the migrants reduce their families' additional burden of support. Their remittances also increase family income.

Push factors encouraging migration:

- escape poverty through greater work opportunities
- obtain jobs for those who do not have professional skills
- escape from a boring rural life with poor living conditions
- escape from troubles (family conflict, broken home)

Pull factors facilitating migration:

- plenty of opportunities that they do not have in their communities of origin
- availability of social support
- plenty of excitement in big cities
- offers a more private lifestyle than communities of origin

Among married female adolescents in particular, the major reasons for their migration were to relieve the family burden, as well as the need to care for their children and husbands in Bangkok.

The adolescent migrants realize that living in large cities is not a pleasant life, as they had originally anticipated, though it is a much livelier, private place to live than in their communities of origin. In the cities, they must work hard to survive while also sending money back home. Nonetheless, socio-economic opportunities and future prospects are far greater in these cities than in the migrants' rural communities.

When adolescent migrants move to large cities, they are not left alone to fend for themselves. All of them have existing social networks in these cities that can be called upon in times of need. This support usually comes from siblings or other relatives, friends and employers. These social networks also allow the migrants to explore what types of economic and living opportunities are available to them and where they are located, and these networks serve as an incentive to migrate even before the adolescents leave their families of origin.

Reproductive Health Behavior and Risks

Unmarried adolescents

Regarding reproductive health behavior and risks, study results show that unmarried male adolescents have more sexual freedom. Their pre-marital sexual relations are not condemned, unlike the case for young unmarried adolescent women who, it is believed, should remain virgins and avoid premarital sexual relationships, or they run the risk of being gossiped about and condemned by their neighbors. They can also bring shame upon their families and risk being labeled as an "easy girl."

A double-standard still exists in Thai society with regard to gender norms.

For young unmarried female adolescents, conventional norms that restrict their sexual relations can serve as a safeguard against sexual and reproductive health risks.

There is, however, a distinct period when they are at risk, despite these norms. Specifically, once a couple agrees to marry, prevailing attitudes and norms are suspended and it is acceptable for them to have sexual relations as long as the woman does not become pregnant and deliver a baby before marriage. Consequently, this engagement period is the time when reproductive health interventions, including HIV/AIDS prevention, are most critically needed. The couple needs to know about safe sex to prevent infection as well as about contraceptive methods and their proper use to prevent unwanted pregnancy, unsafe abortion and its complications.

For those young women who want to avoid a pre-marital sexual relationship during courtship, they will adopt a variety of preventive actions. These usually include avoiding being alone with their boyfriend, finding someone to be their “guardian,” or they will threaten their boyfriends that they will stop the relationship.

For young male migrants, their attitudes towards premarital sex are both positive and negative. Those in favor of it feel that it is a normal practice among youth at present. Moreover, cohabitation can help the couple learn about each other and help in earning a higher income while living in Bangkok. Among young men who were against premarital sex, they offered a more conventional view stating that they did not want to hurt their parents' feelings or run the risk of ridicule by community members. Nonetheless, in the eyes of young unmarried men, they would prefer girls who were virgins. However, some young men noted that it is difficult to find such girls now.

When comparing unmarried migrants, study results indicate that younger adolescents are more conservative than their older counterparts. One of the possible reasons for this is that older migrants have more sexual experience, and they also realize the economic advantages of taking on a partner.

Both male and female migrants know how to prevent pregnancy by taking oral pills for women and using condoms for men. Some know about additional contraceptive methods, such as the emergency pill or abstinence. However, in any case, the burden of contraceptive use usually falls on women.

The burden of contraceptive use usually falls on women.

Regarding HIV/AIDS prevention, the single male migrants perceive that they are not at risk because they are not promiscuous. They feel that they know how to prevent HIV/AIDS by using condoms for safe sex. In addition, men should not visit prostitutes or be promiscuous, and they should have their blood tested. The men, however, do not know how to protect women as part of safe sex. *In other words, women should know how to protect themselves not to depend solely on men.*

However, the unmarried female youth also perceive that they are sexually safe so that they do not need to protect themselves.

Both unmarried male and female migrants show little knowledge on the prevention of STIs. While HIV/AIDS has received great attention for many years, other STIs have been neglected. *The adolescents only realize that they should use condoms for prevention and see a doctor for treatment.*

Single male migrants perceive that they are not at risk of contracting STIs and HIV/AIDS.

Married Adolescents

Young married adolescents, both men and women, hold to the norms that married men should be faithful to their wives. An extra-marital sexual relationship can also lead to disease transmission, especially HIV/AIDS.

Though the young men in this study claimed that they have never had an extra-marital sexual relationship, they understand why some men may do so. However, they—as well as their female counterparts—are totally against women having such relationships. *This reflects the double standard that exists in Thai society, where men are free to have extra-marital sexual relationships but women cannot.*

Some of the young couples are practicing contraception usually in the form of oral pills that are purchased at nearby drugstores without a doctor's prescription. Some women are not using contraception because they want to have children. Only one woman in the study felt that the responsibility for using contraception should be with both the man and the woman; most perceived that it is the woman's role, especially since some husbands have little knowledge about female contraception.

Most of the adolescent migrants had little knowledge about contraceptive methods in general. Some married women do not understand the concept of dual protection. They believe that a condom should only be used to prevent disease transmission and not for contraception. Regarding male contraception, they only know about sterilization.

Adolescent migrants, in general, do not understand the concept of dual protection when using a condom.

Overall, married couples know more about HIV/AIDS than STDs, but they have never afflicted with these diseases. They perceived that they are not at risk because they do not have extra-marital sexual relationships. Moreover, the young wives trust their husband who they regard as good men.

Condom use is rare among Thai couples because it is believed that a condom is for commercial sex workers only. Wives have no power to negotiate with their husbands

for condom use even when the wives are not sure about their husbands' behaviour. They try to prevent disease transmission by cleaning and washing their bodies after sexual intercourse.

Views on unwanted pregnancies and abortion are different between unmarried and married adolescent women. A married couple (men and women) will accept an unwanted pregnancy because they view induced abortion as a sin and dangerous for the health of the mother and child. Conversely, a single woman's decision will depend on her partner. If their partner accepts the pregnancy, then the problem is solved. If not, the woman will continue the pregnancy, and send the baby to be raised by her parents.

Abortion is the last resort for unmarried women, and most likely it will be unsafe.

Sources of Reproductive Health Information and Services

Sources of Information

Lack of knowledge, inaccessibility to and the unavailability of reproductive health information and services prevail among the adolescent migrants in this study. One of the reasons for this situation is that the adolescent migrants do not perceive themselves to be at risk, thus they do not actively seek out information on reproductive health. In addition, social norms make it inappropriate for unmarried persons—especially female adolescents—to be knowledgeable about sexual behaviors, safe sex and contraceptive methods. Finally, the adolescents in this study have proven to be a select group. They are determined to earn an adequate income and reduce the poverty that they faced in their communities. They also know the consequences of risky behaviors in achieving this goal.

Social norms make it inappropriate for unmarried female adolescents to be knowledgeable about sexual behaviors.

The adolescents have heard information about AIDS, condoms, and birth control, but they do not pay much attention to. Their main source of information before they moved to Bangkok was interpersonal communication, such as resource persons who were invited to educate pupils in primary schools. Some learned from health personnel at health centers in their place of origin. After they moved, they received information mainly from television, documents and posters in hospitals or clinics, the workplace, and doctors, especially among married women.

Reproductive Health Services

Targeting improved reproductive health services and information rests firstly on identifying which service delivery points adolescent migrants prefer to use when they become ill and why. *Though at first one would assume that accessibility is a*

major factor, findings indicate that other important considerations must be taken into account, or may even play a more important role than access. These include convenience, cost, professionalism, confidentiality, coverage by an insurance scheme, as well as familiarity with health services and providers.

The health status of the adolescent migrants is generally good because they are young and rarely ill. If they become sick, they first buy medicine from drugstores nearby to relieve their symptoms. Alternatively, they will go to private clinics that are not so expensive but more convenient. Migrants do not complain about health cost even though they have to pay more than 30 baht, which is the fixed cost of the government's universal coverage health scheme. However, although the adolescent migrants work and live in Bangkok, they usually use the health and social services in their hometown (including schools for their children by sending their children to be cared for by grandparents). For health services especially, they feel more comfortable with the services in their communities of origin because they are more familiar to them. In this case, accessibility to services does not equate to ones that are preferred and "user-friendly."

Accessibility to services does not equate to ones that are preferred and "user-friendly."

Indicators or Signs of Sexual Risks

Analysis of the qualitative data from interviews with male and female adolescent migrants in Bangkok is also shedding light on signs and safeguards concerning sexual risk taking among male and female adolescents.

Male adolescents

Social Immunity	Risks
No girl friend	Existence of girlfriend
Never use of commercial sex workers	Sexual experience and use of commercial sex workers
Use of condom during all sexual encounters	Irregular use of condom during sexual encounters
Knowledge of reproductive health including safe sex	Little knowledge of reproductive health especially safe sex
Access to advice about sexual matters	No access to advice about sexual matters
Knowledge of dual protection	No knowledge of dual protection
Knowledge of HIV/AIDS, STIs, and mode of transmission	Little knowledge of HIV/AIDS, STIs, and mode of transmission
Strong social networks and support	Weak social networks and support
Avoidance of alcohol consumption	Alcohol consumption behavior

Social Immunity	Risks
When prevailing attitudes and norms are abided by	When prevailing attitudes and norms are suspended

Female adolescents

Social Immunity	Risks
No boy friend	Existence of boy friend
Ability to negotiate with their partners concerning safe sex and condom use	Permissiveness
Knowledge of self protection	No knowledge of self protection
Use of condom during all sexual encounters	Irregular use of condoms during all sexual encounters
Reproductive health information seeking including on safe sex	No reproductive health knowledge including safe sex
Access to advice about sexual matters	No access to advice about sexual matters
Knowledge of dual protection	Little knowledge on dual protection
Knowledge of HIV/AIDS, STIs, and mode of transmission	Little knowledge on HIV/AIDS, STIs, and mode of transmission
Strong social network and support in health seeking	Weak social network and support in health seeking
When prevailing attitude and norms are complied	When prevailing attitude and norms are suspended

Perspectives of Health Service Providers

Identification of “Adolescent Migrants”

Adolescent migrants are not classified in health service medical records. The hospital records aggregate the number of patients as 15-59 years old, as well as 60 years old and above who are considered at present as “old people,” a special group for health care. The reason why adolescents are not differentiated is because the prevailing policy is for “public health” and not for a specific group.

The service providers estimated that about 5-10 percent of clients are adolescents and most of them are students. They felt that only 2-5 percent are adolescent migrants who usually work on construction sites. However, they are not certain whether they are actual migrants, by our definition, or that they are simply the Northern and Northeastern people. The service providers noted that some of migrants who work in the formal sector, such as factories, do not use public

hospitals because they have health insurance so they can go to a registered private hospital. Moreover, factories generally have their own health clinics.

Availability of Reproductive Health Services

Adolescents are not a primary target group for health services because, it is generally believed, “they are healthy.” Reproductive health service that have been available for a long time include: family planning, ANC, MCH, and STIs. HIV/AIDS and cervical cancer were added later, as well as counseling. These services are aimed at married women, mothers, and children, not obviously for unmarried women or adolescents.

Accessibility to Reproductive Health Services

Adolescent migrants and health service providers gave similar responses regarding access to reproductive health services. Results show that when adolescent migrants become ill, they first resort to buying medicines from drugstores or they will go to private clinics, both of which are more convenient, sometimes, less expensive, and offer a higher degree of confidentiality. Moreover, migrants who are ill are not easy to find, and it is difficult for health providers to keep records on follow-up actions because the migrants always move around. This problem is becoming less prominent, however, with the advent of the mobile phone, which many adolescent migrants possess.

Drugstores and private clinics are preferred because they offer a higher degree of confidentiality and privacy than other facilities.

Obstacles to Reproductive Health Services

Adolescents also want privacy when using a health service. At a crowded hospital, the counseling unit is not in a soundproof room, so everyone can hear what is being said. At other public health services, such as VD clinics or gynecological sections of hospitals, adolescents are uneasy because *they feel that they are being condemned for their misbehavior*. Moreover, there is no clinic for male patients, so men rarely seek reproductive health services.

However, the main barrier obstructing access to health services by migrants is the government’s Universal Health Scheme, or 30 Baht Scheme, which was launched on 1 October 2001. This low-cost service is offered to the registered population in certain designated areas. Adolescent migrants who are not registered cannot use this scheme. Most of them own alternative treatment by using social insurance, drugstore and private clinic.

The top-down policy is another barrier to accessing health service. Health practitioners are oftentimes assigned to take care of an urgent campaign on a certain disease or a special health promotion effort. Consequently, they have an enormous

workload. They have no time and no energy to think about adolescent migrants or strategic planning to this specific group.

The health service providers also disclosed that available reproductive health services are not gender sensitive. They are targeted at female clients who are seeking family planning, as well as maternal and child health services. There is no room for male clients who need reproductive health service. Moreover, male adolescents are not frequently noted in hospital registration. *Service providers are also prone to be generalists, not specialists, in taking care of adolescent health.*

Formal RH services are targeted at female clients. There is no room for male clients who need RH services.

Barriers to Reproductive Health Information and Services

In summary, some of the barriers that obstruct adolescent migrants' access to reproductive health services include the following. These affect the unmarried group most heavily.

1. They do not perceive themselves as a risk group so they do not seek reproductive health information.
2. They do not want to learn because if they are unmarried, they should not know about sexuality, according to social norms.
3. If they have reproductive health problems, they dare not reveal them. They assume that STIs are diseases of men only.
4. They do not know about appropriate health services to treat their reproductive health problems.

Emerging Issues

In-depth interview data also revealed other emerging problems of people in Bangkok and its vicinity. Firstly, there are many cross-border migrants. If they have children below the age of 15, these children cannot be hired to work nor do they go to school. Adolescents who are working as illegal laborers (e.g., construction workers) are not registered. Consequently, they do not have social insurance so they cannot access health services.

Secondly, construction workers who are from rural areas of Thailand have this same problem. Moreover, children who accompany their parents usually do not go to school, and many require health services at their place of destinations.

Thirdly, in the opinion of health service providers, the most at-risk group for reproductive health problems are working men (aged 30-40) and their wives who are at risk because of their husbands' sexual behavior.

Fourthly, adolescent students are also at risk, since they have incorrect knowledge and beliefs about contraception (e.g., using emergency pills). They are prone to unplanned pregnancies and unsafe abortions. Students are a dominant group among adolescents who use reproductive health services because they are familiar with health personnel who teach sex education in their school health course.

Special groups needing attention are:

- *Cross-border migrants*
- *Children of construction workers*
- *Adult male workers and their wives*
- *Students*

CONCLUSION

Based on the data, reproductive health risks of adolescent migrants can be divided into four major dimensions.

(1) *Behavior.* Results show that most adolescent migrants—men and women in this study —are still conservative with regard to their sexuality. The behavioral codes concerning sexual relations that have been socialized by the adolescents in their communities of origin are still strong. They provide some degree of social immunity and serve as a safeguard against reproductive health risks. The period when these safeguards are removed is when a couple becomes lovers and is planning to get married. This is the period in which reproductive health information and services can play an instrumental role in preventing disease and unwanted pregnancies.

(2) *Information.* Lack of accurate reproductive health information places adolescent migrants at risk. This is especially the case for adolescent males who frequent commercial sex establishments and who may already have or will soon have a girlfriend who, in turn, may be at risk. Increased accessibility to proper reproductive health information is thus urgently needed. This information, moreover, should be distributed at locations where adolescent migrants feel comfortable in obtaining it, such as free brochures distributed at convenience stores or private clinics.

(3) *Perceptions.* Inadequate information and the means for its communication also limit the perceptions of adolescent migrants. They do not consider themselves at risk, thus they do not seek measures to protect themselves.

(4) *Services.* Reproductive health services target largely married women, which restricts access by unmarried adolescent migrants. Moreover, lack of knowledge about reproductive health services designed specifically for unmarried adolescents makes adolescent migrants vulnerable. Improving the quality of reproductive health

services so that they are convenient and affordable, where confidentiality is assured, and the health service providers are professional, yet understanding regarding the reproductive health needs and concerns of adolescent migrants, could go a long way in increasing use of such services, not simply access.

In summary, on the one hand, and based on behavioral data, adolescent migrants especially young women—appear to be safe from sexual and reproductive health risks. There is only a certain period when they begin to be at risk (e.g., engagement to be married). On the other hand, however, the data related to other dimensions—perceptions, information and services—reveal that they are not well equipped to protect themselves against reproductive health risks, including prevention against HIV/AIDS, STIs and unwanted pregnancies. These represent the urgent areas for improvement that policy makers, programmers, researchers, interventionists and other concerned organizations must immediately address.

Based on this study's results, the following recommendations can be made.

1. Identify and develop a proactive approach to increase the access of adolescent migrants to reproductive health services, such as through mobile clinics.
2. Because of the regular workload at health centers and hospitals, part-time personnel should be employed to provide adolescents (including adolescent migrants) with appropriate care and counseling and using a special schedule.
3. Implement a sex education unit that is responsible for educating students in schools as well as out-of-school adolescents at their work places.
4. For out-of-school adolescents, they should be encouraged to receive sex education, or at least reproductive health information, before they leave schools in their hometown.
5. For students in schools, they should learn sex education from health personnel, such as doctors or nurses, because teachers have less knowledge and are less experienced in sex education and health related issues. A sex education course should include morality and life skills. Teachers should also be trained to be good counselors.
6. For in-house services, a reproductive health clinic should be located in a place where confidentiality and privacy can be strictly followed.

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Adolescent Migrants and Reproductive Health in Vietnam: Using reproductive health facilities means time lost and treatment costs

Nguyen Trong Hieu and Tran Son Thach

INTRODUCTION

Though Vietnam's economy is traditionally agricultural, it is increasingly becoming export-oriented. Investments made by several overseas agencies and corporations has resulted in a growing need for trained workers, which has increased opportunities for young people to be trained and to access better working conditions. Consequently, adolescents from rural areas are now prone to migrate to urban areas, despite the difficulties they face in adapting to a new socio-cultural environment. In this environment, those adolescent migrants who lack physical and psychological support mechanisms have low accessibility to health services for economic and/or administrative reasons, are subject to bio-psychological stresses, and are predisposed to risks of reproductive disorders and abnormalities. Moreover, little information on reproductive health care is available to adolescents and, in particular, adolescent migrants.

A study conducted by Hung Vuong Hospital in 1997 involving 1,500 high school students in Ho Chi Minh City revealed inadequate knowledge, negative attitudes and poor reproductive health practices, especially among those who were sexually active. Most likely, this situation is even worse among adolescent migrants. This finding echoes that made at the International Conference on Population and Development (ICPD), which highlighted the importance of adolescents' needs and perspectives with regard to sexual and reproductive health. In many societies, including Vietnam, adolescents are increasingly at risk of contracting STIs including HIV/AIDS. They are poorly informed about how to protect themselves from unwanted pregnancies, young motherhood and unsafe abortion. They are also the group that has been largely ignored by existing reproductive health services. Among adolescents, migrants are a particularly high-risk group, especially when the service structure does not meet their needs and does not take their constraints into consideration, such as working time and income level. In most settings, adolescent migrants—especially unmarried ones—are not expected to come for reproductive health services (e.g., treatment, counseling) provided by the government sector, whereas there are costs encountered in attending private clinics and practitioners for such purposes. Within medical facilities, moreover, the quality of service is not always high.

Adolescent migrants thus constitute a vulnerable group, and they are often subject to physical and psychological stresses that predispose them to reproductive health risks. These risks are greater than among non-migrants, moreover, because adolescent migrants are away from the controls traditionally imposed upon them in their rural family settings.

METHODOLOGY

This qualitative study was conducted in Ho Chi Minh City. It is the most industrialized city in Southern Vietnam with a population of 6 million, as well as a substantial migrant population. Administratively, the city consists of 16 urban and 6 rural districts (226 urban and 76 rural communes), of which only 3 rural districts (38 communes) are considered as without “pull factors.”

The study’s objective was to obtain in-depth information on adolescent migrants regarding their reproductive health status, their accessibility to reproductive health services, and potential barriers.

The study entailed in-depth interviews with 65 male and female adolescent migrants aged 18-24 years living in four settings:

1. Construction sites: Construction project of Hung Vuong Hospital and that of Ngo Gia Tu school in Commune 15 District 8.
2. Factories: Food Processing Factory Thang Loi on Binh Thoi Street, District 11 and Textile Factory in Tan Binh District.
3. Service areas: Binh Tay Market and An Dong Market.
4. Slum areas: on Au Co Street and Luy Ban Bich Street (District 11) and Nguyen Duy Street (Commune 14, District 8).

The adolescent migrants who voluntarily agreed to participate in the study were divided into eight groups based on sex, marital status and living arrangements:

- Group 1: unmarried males currently living with relatives other than parents,
- Group 2: unmarried females currently living with relatives other than parents,
- Group 3: unmarried males currently living alone or with friends,
- Group 4: unmarried females currently living alone or with friends,
- Group 5: married males currently living with their wives,
- Group 6: married females currently living with their husbands,
- Group 7: married males not living with their wives, and
- Group 8: married females not living with their husbands.

In addition, in-depth interviews were conducted with 16 reproductive health service providers who voluntarily consented to participate in this study. Eight of these participants were doctors and eight were either midwives or nurses working in reproductive health service facilities. These groups can be divided into the following interview categories.

1. Four interviews with doctors and midwives working in two OBGYN hospitals: Tu Du and Nhan Dan Gia Dinh,
2. Four interviews with doctors and midwives working in two government gynecology clinics: Tan Binh Medical Centre and Nguyen Tri Phuong Hospital,
3. Four interviews with doctors and midwives from two Gynecology clinics of private hospitals: Trieu An Hospital and the International Hospital for OBGYN, and
4. Four interviews with doctors and midwives from two private clinics.

RESULTS

Reasons for Migration and Its Consequences

Very few participants moved because they were attracted to modern, city life. The most common reason for migrating to the city was to earn money. In addition, common push factors included poor family relationships and unfavorable housing conditions.

I am 20 years old. I was born in An Giang (a province of Mekong Delta in South Vietnam). My mother died when I was just 11 years old. Two years after, my father married another woman. Three younger brothers of mine and I moved to live with my aunt who is my mother's sister. But my aunt's family, who was also very poor, could not handle the burden of the four of us, so I had to move further to Ho Chi Minh City [HCMC]. (Female migrant)

Many migrants soon learn that city life is hard, and the chance to earn money is difficult. Many become pessimistic, such as this young male migrant.

I moved to HCMC three years ago from Quang Tri province, a very poor area in Middle Vietnam. I wanted to earn much money to help my elderly parents. At present my job is, like many others, so simple and boring; carrying things from the store to the river. A very unstable job, isn't it? That's right, because everyday my friends and I have to queue along Binh Dong riverside, waiting for labor requests from the boss. The more I carry,

the more money I earn. Day by day, I feel myself like a robot without feeling or emotion. Two years ago I got married. My wife, also a young migrant, sells miscellaneous things at the market nearby. We work hard but our total income is just enough for two persons. We have to send my only son to his grandmother in our home village to be raised. My dream of earning money to support my parents is gone.

Suddenly being separated from their families and moving to the city made most of the participants feel alone, especially if they lived alone or even with friends. Consequently, they tried to work hard to avoid becoming homesick and also to earn more money on which to live and to send back to their families.

I have free time on Sundays when my boss asks everyone to have a weekend. In fact, I am happier if he asks us to work seven days a week. We need money. Without work, I don't have anything to do. I'm different from the others. I go to bed early. Usually I watch television programs for about an hour before going to bed.

Talking to friends facing similar conditions is an effective way to overcome these social difficulties. But unfortunately, a few young men choose inappropriate ways to adapt themselves to their new living conditions. During their free time, they drink alcohol, play cards, and use up the money they had made. In the end, they have no money left.

Reproductive Health

Most of the single respondents thought they were in good health, but some married men felt that they were not very healthy due to their heavy workloads.

Premarital sex

Due to prevailing socio-cultural beliefs, women are more conservative in terms of premarital sex.

In the culture of my hometown, virgins must be protected until marriage. My parents told me many times before I left that I must keep this in mind and they would not forgive me if I fall into trouble. Personally, I find premarital sex unacceptable without any exception. Many girls have regretted falling into trouble because of it. .

Regarding premarital sex among young migrants, both single and married adolescents in this study tended not to support it. This is in line with another study in Vietnam, which found that only 10 percent of males aged 15-22 and only 5 of

females in the same age category had experienced premarital sexual relations (Mensch et al., 2002).

I have no girlfriend, but if I had had one I would never ask her for sex. If a man loves his girlfriend, he must prevent the couple from any trouble. (Male migrant, aged 20 years)

Even unmarried adolescent migrants are still under the social control of their families of origin.

I've never thought of premarital sex before. My family is poor, and my parents said I must be serious about sex. I remember the first time I had a friend (not a true girlfriend) when I was still in my home village. She was just a classmate of mine. We went together to school and did our homework together. We often studied at my house together. My father did not object, but he kept reminding me that there is a limit between two friends of the opposite sex. Now that I am far from my family, I keep this in mind, what my father told me. This should be a rule a bachelor should follow, at least until he gets married.

Another man, who has a girlfriend, also did not support premarital sex.

I actually have a girlfriend. We are both migrants from other parts of the country. I am from the South, and she is from Central Vietnam. We do not plan to go back to our home villages, and to get married probably after two years when our economic status improves. We treat each other as close friends; we share our thoughts of life. But we have something like an agreement regarding sex. We want to keep on loving each other, but only have sex after marriage.

Among the adolescent migrants who do not support premarital sex, they valued a woman's virginity and building a good family in the future. These are common social norms that are found especially in Vietnamese families and villages.

For those who are less conservative, they feel that the concept of virginity is not as strict as it was in previous times and that premarital sexual relations are acceptable. Moreover, when a young woman is more liberal with regards to sex, then her boyfriend will be less conservative, especially if they plan on getting married. Otherwise, it is unacceptable for a man to persuade a young woman to have sexual relations if there is no firm commitment between them. This finding is in accordance with a previous study which revealed that the vast majority of Vietnamese adolescents are not engaging in premarital sex. Of those young women

who are doing so, they are having sexual relations with their future husbands (Mensch et. al, 2003).

Among married adolescents, once again premarital sex is not acceptable.

As a married man, I realize that most husbands wish they were the only man, or at least the only sexual partner, of their wives. When a man and a woman are not sure of their marriage, they shouldn't have any sexual contact to avoid trouble for the woman in case she has to marry another man.

From my own experience, I think a man would hardly accept to be the second person in his wife's sexual life.

Related to the unacceptability of premarital sexual relations, male adolescent migrants do not have any skills in negotiating with their partner on sex. Similarly, female adolescent migrants did not know how to resist when asked for sex.

Prevention of Pregnancy

Both male and female adolescent migrants believed that a man and woman are responsible for preventing pregnancy, though a woman plays a more important role since she must carry the pregnancy.

HIV/AIDS

Although information about HIV/AIDS is currently provided through the mass media, many young migrants had limited knowledge about it. They usually know that it is a dangerous disease ... *that may kill a healthy person...*, but they cannot accurately state how the disease is transmitted. Sometimes, though, a participant could give an acceptable answer.

I heard that a woman contracting the disease might transfer it to her baby. Is this true? Then to avoid bad outcomes, a woman should have only one sexual partner, as I have been told. Maybe this not enough but this is all that I know about AIDS.

Many respondents did not know anything about HIV/AIDS. With the following young woman, a friend of hers reported that she became HIV positive because she lived in the same house as an AIDS patient. She did not understand, or would not admit to, her husband's possible role in disease transmission.

As I understand it, one can contract HIV if she lives in the same place as an AIDS patient. I had a friend who was not a migrant like me. She was a native of this city and from a rich family. She was married last year and got pregnant a few months ago. When she had her blood tested as a routine

procedure for screening communicable diseases, the hospital reported that she was HIV-positive. She told me she knew the reason was that her house employee was HIV-positive, which made her become infected.

Information on HIV/AIDS comes mainly from television programs. Each household has at least one television in Ho Chi Minh City, and some of the study's participants could spend time watching television programs. For those adolescent migrants who had little knowledge about HIV/AIDS, they usually obtained incorrect information from friends or other unreliable sources.

Knowledge on HIV/AIDS and STIs is still limited among adolescent migrants. The usual sources of information are inaccurate.

Sexually Transmitted Infections

Knowledge on STIs was, again, limited. Respondents often sought information on STIs from friends, while seeking information from the mass media was not common. When an explanation was given about the term STIs, some respondents had no idea what was being discussed or understand its importance.

No, I have no sexual contact, so I don't need to know what STIs are. If I was affected by such diseases, I might consult my friends. I have many friends who are older and more experienced than me in terms of such diseases.

Some participants tried to appear familiar with information on STIs, but later they could not give a correct answer to some simple questions.

I've heard of gonorrhea for some time, from my older friend who lived with me in the same house. This is a disease that is very simple to cure. My friend told me every time he contracted gonorrhea, he just went to see a nurse nearby for an injection, probably of antibiotic, and that's all. All the disease is gone. And again and again. Nothing serious. That's also what I am thinking about doing if I get gonorrhea. Am I right?

Married adolescent migrants were more concerned about STIs, but their level of knowledge was still limited. Some married women had experienced gynecological problems, but they never sought medical care due to the cost and lack of free time. *Most respondents were unaware of the reproductive health service system.*

However, a young woman working in a textile factory proved to be an exception. She was married, had no living child, and had undergone two induced abortions. She received reproductive health services from a doctor at her work place and then a hospital. She was told she needed an operation, but she could not afford it because she would not be able to work for a long time.

In my factory, all women are routinely checked once a year. I was examined, and the doctor said my uterus had a tumor that needed to be removed surgically. I was referred then to a hospital. After the examination, the doctor suggested that I be hospitalized, but, at the time, I thought I couldn't ask for work leave (at least one week) so I went back to work, until now.

In general, the ability of adolescent migrants to care for themselves and their reproductive health was inadequate, due to their lack of income, lack of free time, and lack of knowledge and information about reproductive health.

For RH treatment, adolescent migrants can not afford long work leave and hospitalization.

Responsibility for Preventing HIV/AIDS and STIs

Many participants emphasized the role of a man in preventing STIs including HIV/AIDS, since they believed that the diseases might be transmitted to the man when he had sexual contact with other partners. Using a condom to prevent transmission to their wives was not practiced by married men because they do not want their wives to know their infected status.

Preventing STIs and HIV/AIDS is a man's responsibility.

Had I told my wife that I has gonorrhea, she might have killed me. That's why I kept silent and tried to avoid sexual contact with her as long as I could.

Perspectives of Service Providers

Reproductive Health Services and Government Policy

In the government sector, different levels of health facilities are responsible for different levels of care. Family planning services are provided to people within a specific area at any reproductive health service facility, whereas STI patients may need to be treated at the Hospital for Skin and Venereal Diseases. For diagnosis and treatment of gynecologic conditions, patients must attend OBGYN hospitals, whereas those who suffer malignant diseases must be referred to the Centre of Oncology for specific management.

Private facilities have more open policies. These facilities may provide a wide range of reproductive health care, from the simplest to the very complicated, depending on the facility. The clients of private facilities may come from different geographic areas, or even from other provinces.

Attitudes Towards Reproductive Health Services for Adolescent Migrants

In general, many physicians were aware of the need for reproductive health services for adolescent migrants.

They have to live in unfavorable conditions, most of them far from their families. They are also in a critical reproductive health period, since they may be sexually active and experiencing physical and emotional difficulties.

Service providers felt that marital status does not really affect the need for reproductive health care, although young migrants may need more services if they are married. But for those who are single, the risk of unwanted pregnancy is high, since they do not have adequate knowledge about contraception. They are also more susceptible to STIs because they do not know how to prevent them.

Physicians at reproductive health service centers treat adolescent migrants like any other patients. They did not segregate patients out as being a “migrant” or “non-migrant”, especially at private facilities. They put everyone into one category: “patients”.

Barriers to Accessing Reproductive Health Facilities

No discrimination exists between those who are registered and those who are not in Ho Chi Minh City in terms of access to reproductive health services. However, time lost and treatment costs are barriers. One physician at a government reproductive health service facility noted that *service time is not convenient for the patients* (adolescent migrants).

Major barriers to access are time lost and treatment costs.

When a young woman has a gynecological problem, she must spend a lot of time for the examination, which affects her daily income. This is why many female workers never seek reproductive health care at this facility.

Visiting a private doctor could be more convenient, but usually it is not affordable to young migrants. A female private doctor who worked for a government hospital during official time and at her private clinic in the evening, said:

Some patients of mine who are young migrants have complained about the treatment costs. I don't want them to spend a lot of money. I even suggested them to see me at the government hospital in the morning, but they could not be there during their working time.

Adolescent Migrants' Access to Reproductive Health Services

In general, adolescent migrants seldom sought care at reproductive health service facilities, and this is especially the case for unmarried adolescents. The situation is even worse at government services, where doctors' attitudes towards adolescent problems are usually not positive.

Adolescents seldom go to RH services where doctors' attitudes are not supportive.

I have to examine more than one hundred patients a day. This workload is continually terrible. Usually I don't have time to talk to the patients, because I could spend only 2-3 minutes for one patient.

Anyway I think more attention should be paid to adolescent patients to help them overcome their troubles. Sometimes, they come for counseling after making stupid decisions, such as getting involved too early in sexual activities, getting pregnant, and undergoing induced abortion. I see this again and again.

Ways to Improve Adolescent Migrants' Reproductive Health

When reproductive health providers were asked about how to improve the reproductive health of adolescent migrants, most mentioned the role of the family and the society. In addition, improvements are needed in health insurance coverage for company workers, as well as in health education through the mass media.

A physician could do just a few things to help adolescent migrants. But a better social environment could do more. For example, if a migrant could seek health care when he/she gets sick without the fear of losing his/her daily wages, and they correctly follow treatment advice, their reproductive health would be improved. More effective policies on health insurance would also help.

With reproductive health related problems, I wish they could have better access to health education programs on television and in the newspapers, rather than asking friends for their experiences.

CONCLUSION AND RECOMMENDATIONS

The results of this project revealed that the main reasons for adolescents to migrate to cities were poverty and unfavorable living conditions in their rural communities. But even after migrating to the city, few respondents found their living conditions to be satisfactory.

Most of the adolescent migrants in this study, either married or unmarried, did not accept premarital sex, which is in line with the prevailing socio-cultural norm. The prevention of pregnancy is thought to be the responsibility of women, while STI prevention is the responsibility of men. Their knowledge about reproductive health, STIs and HIV/AIDS was also limited, with most information being supplied by friends and relatives. In many cases, this information is incorrect, which places the adolescent migrants at greater risk of reproductive health complications.

Access to reproductive health care, especially among unmarried migrants, was also very low, due to inadequate information about the reproductive health care system, socio-cultural norms regarding premarital sex, the poor attitudes of health service providers, and, especially, treatment costs and the inconvenient time of reproductive health service facilities.

Several recommendations can be made to improve the reproductive health of adolescent migrants in Vietnam.

1. Any discrimination among patients attending reproductive health services in terms of their residence/migration status should be abolished. In addition, health providers at reproductive health service facilities need training in interpersonal skills so that they communicate positive attitudes to their clients, and especially adolescent migrants.
2. Adolescent migrants need more social support and better information about reproductive health education and services in their home communities and at their workplaces in the city.
3. Reproductive health knowledge and the accessibility of adolescent migrants to reproductive health care should be effectively increased through the mass media; out-reach programs, such as mobile clinics; and peer education training programs, which could be conducted at their workplaces (possibly in conjunction with workplace health examinations) or where they live.
4. The health insurance policy should be reviewed and strengthened in order to cover reproductive health services for adolescent migrants.

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Are Adolescent Migrants in the Greater Mekong Sub-region Equipped to Protect Themselves Against Sexual and Reproductive Health Risks?

Bencha Yoddumnern-Attig, Chanya Sethaput, Supanee Pluemcharoen and Jirakit Boonchaiwattana

INTRODUCTION

Previous research on adolescents and reproductive health has concentrated mainly on adolescents, in general, how and why they are at risk, and how to improve their sexual and reproductive health. Only a few studies have touched upon the adolescent migrants and reproductive health. (cf. Charoensup, 2003; Chaichana et al., 2003; Ford and Kittisukhsathit, 1996; Zhang, 2001) However, a knowledge gap exists in understanding the livelihood's of adolescent migrants and, in particular, how they sustain and balance their productive and reproductive lives.

The research project on Adolescent Migrants and Reproductive Health in the Greater Mekong Sub-region is an attempt to fill in this gap. It is also the only comparative study dealing with adolescent migrants and reproductive health in the four participating countries of China, Lao PDR, Thailand and Vietnam. Within each country, furthermore, the research findings are filling glaring gaps in existing information available for formulating reproductive health policies and implementation programs aimed at adolescents, in general, and adolescent migrants, specifically. This chapter—a synthesis of such an attempt—has three major purposes:

Firstly, to build a clearer picture of the commonalities and differences in reproductive health issues in the four participating countries in the Greater Mekong Sub-region;

Secondly, to assess whether or not the adolescent migrants in the four participating countries are equipped to protect themselves against reproductive health risks; and

Thirdly, to prioritize the future activities that would equip adolescent migrants to protect themselves against reproductive health risks and that ultimately could lead to a reduction in reproductive health risks among adolescent migrants in the Greater Mekong Sub-region.

COMMONALITIES AND DIFFERENCES IN REPRODUCTIVE HEALTH ISSUES

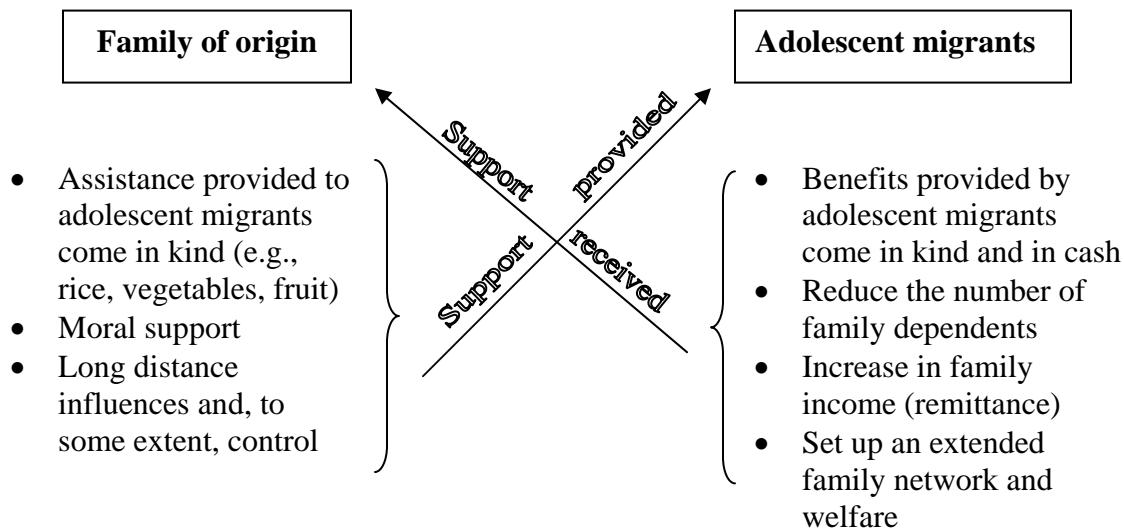
Reasons for Migration

Clearly, the picture of adolescent migrants that has emerged from the four participating countries is similar. These adolescents are poor, young and healthy; they have moved away from their traditional rural families and communities and into a more liberal urban environment; and they are striving to survive on what meager earnings they make, while at the same time supporting their families.

Adolescent migrants in the four countries share similar reasons for migration, which cover both push and pull factors. The major force that led the adolescents to migrate was their desire to escape from poverty through better work or educational opportunities in large cities. Improving their lives as well as those of their family members is another driving force that urged them to move.

Usually, remittances flow from the migrants in the cities to their families of origin in rural areas; not the other way around. Any assistance provided by the family of origin to the migrants usually comes in kind not in cash (Figure 1).

Figure 1. Support flows between adolescent migrants and families of origin



Social Networks as Support and Control

Social networks in the big cities play a significant role in the lives of adolescent migrants. These networks provide information related to available jobs, education, lodging, as well as moral support. Similar findings were found in an investigation of the relationship between social networks and the job searching activities among

young, unemployed Japanese. Those who have an “expanding social network” were more likely to get a job faster than those whose networks were limited (Hari, 2005).

The evidence from the four participating countries points in the same direction as observed by Bondieu (1985) as well as Portes (1998). An adolescent migrant’s social network (social capital) can be a significant resource that he or she can tap in times of need (either before and after migration), as well as a form of social control. In our study, although familial control over adolescent migrants’ behavior (including sexual attitudes and behaviors) is weakened when they moved, their new network in big cities (usually comprised of relatives) continues to serve as an extended form of social control. The adolescent migrants do not have absolute freedom; they cannot do whatever they want to do. They still have ties with their families of origin, and they remain obligated to these families, especially for support. At the same time their urban networks watch over them in their new environment, and they can communicate back to their networks/families at home about what is happening to the adolescent migrants. Consequently, there can be a tendency for traditional rural norms to be upheld even in an urban environment, especially with regard to sexual relationships.

A combination of these three major dimensions involved in the life of adolescent migrants—strong determination to improve economic status, family ties and social networks in cities—serve as a coordinated behavioral control mechanism that imparts some level of protection.

Gender Inequality in Reproductive Health Practices

The respondents in this study came from a rural background where conventional sexual norms are highly valued. Adolescent migrants also feel that sexual norms are stricter in rural areas than in large urban centers.

The data from the four countries reveal the general pattern that male and female adolescents are not equal in terms of sexual norms. Male adolescents have more sexual freedom than their female counterparts. It is believed that unmarried female adolescents should remain virgins and avoid premarital sexual relationships. This is not the case for unmarried male adolescents. Therefore, a double standard still exists in these societies. These sexual norms also dictate whether or not they are eligible to receive reproductive health information and to receive access to services (which largely favor married women to the exclusion of men and unmarried women), as well as responsibility in terms of pregnancy (women) and disease prevention (men).

Gender inequality in this study is a complicated issue. The influence of sexual norms on men and women, in general, varies according to the context of their lives (rural versus urban; degree of social network control) and in what life stage they find

themselves (unmarried or married). Data from this study show that sexual norms can be stricter—and inequalities between men and women more evident—in rural areas than in urban ones, especially when the adolescents are under the direct control of close family networks (rural) rather than indirectly through extended networks (urban). In addition, single, female adolescent migrants have more rights than those who are married, especially in terms of their sexual freedom. And lastly, marriage also gives a clear picture of the inequality between male and female adolescents in relation to sexual and reproductive health practices. In particular, men continue to have greater freedom to enter into extra-marital relationships, while married women are powerless to do so, and, if they do, they risk social stigmatization.

Taken together, gender inequalities between men and women in terms of sexuality and the persistence of a double standard prevail within the four participating countries. Such phenomena have a direct impact on adolescent migrants' lives, and especially on their sexual and reproductive health practices.

Accessibility Does Not Always Mean Utilization

Usually, the health services provided to a population are influenced by top-down health policies, as well as by prevailing social and cultural norms in each country. Evidence from the four participating countries points to the fact that adolescent reproductive health is not yet fully recognized as a priority issue in national health policies. In addition, specific packages and a positive environment for delivering reproductive health services to adolescents, including adolescent migrants, do not fully exist in any of the participating countries.

Coverage by an insurance scheme can potentially play a significant role in improving the reproductive health of adolescent migrants, and adolescents, in general. In the region, however, adolescent migrants are not covered by social or health insurance schemes, unless they work in large factories or companies. In China, because of household registration system, adolescent migrants face many obstacles in employment, education, social welfare and health care (including reproductive health). In Vietnam, the Health Insurance and Social Insurance Schemes have been merged into one entity known as the Insurance scheme. One major aspect that this new scheme needs to consider now is covering reproductive health services for adolescent migrants.

For Thailand, under the Government's Universal Coverage Health Scheme (known as 30 baht health scheme), migrants can use their health insurance card at any public hospital. This means they can readily access the nearest reproductive health service facility. However, this does not automatically mean that they will use this service, especially if its services are considered to be low-quality and its providers are unfriendly. Although the adolescent migrants work and live in Bangkok, they

usually use the health and social services provided back in their hometowns (including schools for their children and sending their children to be cared for by grandparents). They feel warm and secure when surrounded by family members and relatives. For health services especially, they feel more comfortable with the services in their communities of origin because they are more familiar with them. The health service providers also are more attentive and display more positive attitudes in caring for their patients (who they usually know personally). In this case, therefore, accessibility to services does not equate to ones that are preferred and “user-friendly.” Rather, ones that offer a positive and supportive environment in delivering reproductive health services are those that will most likely be used by adolescent migrants. Quality of service thus takes precedence over coverage.

The data from all four countries indicate that adolescents would rather go to drugstores or private clinics than public health facilities (e.g., government hospitals). The data from Lao PDR and Thailand, in particular, reveal their preference for private clinics where health providers treat adolescents professionally and confidentially. A long waiting time, complicated procedures, poor communication skills (as indicated by the data from China and Lao PDR.), time lost (e.g., Thailand and Vietnam), perceived fear at the service cost (e.g., China and Vietnam), lack of transportation and companionship (e.g., Lao PDR.), and poor attitudes of health providers towards adolescent reproductive health behavior add to the complex obstacles that block adolescent migrants’ access to reproductive health services.

Consequently, providing reproductive health services to adolescents (including adolescent migrants) does not involve only accessibility. These services will only be used when the adolescents feel comfortable in coming to them, when providers are friendly and compassionate, when the services are convenient and affordable, and when privacy and confidentiality are assured. One step in starting this process of delivering user-friendly, gender-sensitive reproductive health services is to involve the adolescent migrants, themselves, in planning and implementing these services. Only they know what they really want and will use.

ARE ADOLESCENT MIGRANTS EQUIPPED TO PROTECT THEMSELVES AGAINST SEXUAL AND REPRODUCTIVE HEALTH RISKS?

Despite the widespread assumption that adolescence is a risky life stage due to major sexual and reproductive health threats (Boonstra, 2004; Soonthorndhada et al., 2005; UNESCAP, 2006; United Nations, 2005; WHO, 2006a), this study revealed several protective mechanisms that impart some level of protection against reproductive health risks. These include self-control, as well as familial and social network control.

The adolescent migrants in this study are selective. They are from poor rural areas. They are conventional and have strong ties with their families of origin. All of the

adolescent migrants in the four countries were never alone when they moved to large cities. Existing social networks in large cities played a role in replacing the familial influence in rural areas.

The adolescent migrants have a strong determination to better themselves economically and improve their lives. Adolescent migrants in Yunnan (China), Lao PDR and Vietnam, in particular, hold to the firm idea of settling down in the cities and, if possible, bringing their families to live with them. Hence, they work very hard and have little time for entertainment, especially those forms that would expose them to reproductive health risks. All of these factors work together to serve as a behavioral control mechanism that imparts some level of protection. This type of practice can lead to an “abstinence period” which is one of the most effective strategies for preventing reproductive health threats.

This does not, however, mean that these adolescent migrants are not at risk. Firstly, the respondents reported having heard that some of their friends encountered reproductive health problems. Secondly, it is reported that sexual norms are stricter in rural areas than in large cities due to family control. Thirdly, although the adolescent migrants in these countries hold to conventional norms that restrict their sexual relations, there is, however, a distinct period when they are at risk, despite these norms. It is a period of compromise between strict sexual norms and committing themselves to a long-term relationship. Specifically, once a couple agrees to marry, prevailing attitudes and norms are suspended, and it is acceptable for them to have sexual relations as long as the woman does not become pregnant before marriage.

Regarding information and knowledge on sexual and reproductive health, adolescent migrants are not well equipped *before* moving to large cities. Responses from China, Lao PDR and Vietnam reveal the incomplete and inadequate information that adolescent migrants receive prior to migration. Adolescent migrants in Thailand reported that they have received some information related to AIDS, condom use and family planning in their places of origin, but they did not pay much attention to it, since the information is not directly targeted at them.

The adolescent migrants in the four countries received more information on reproductive health *after* migrating to large cities than in their hometowns. However, their information and knowledge on reproductive health risks, disease transmission and preventive measures are still limited due to the following perceptions.

1. They do not perceive themselves at risk, thus they do not seek measures to protect themselves.

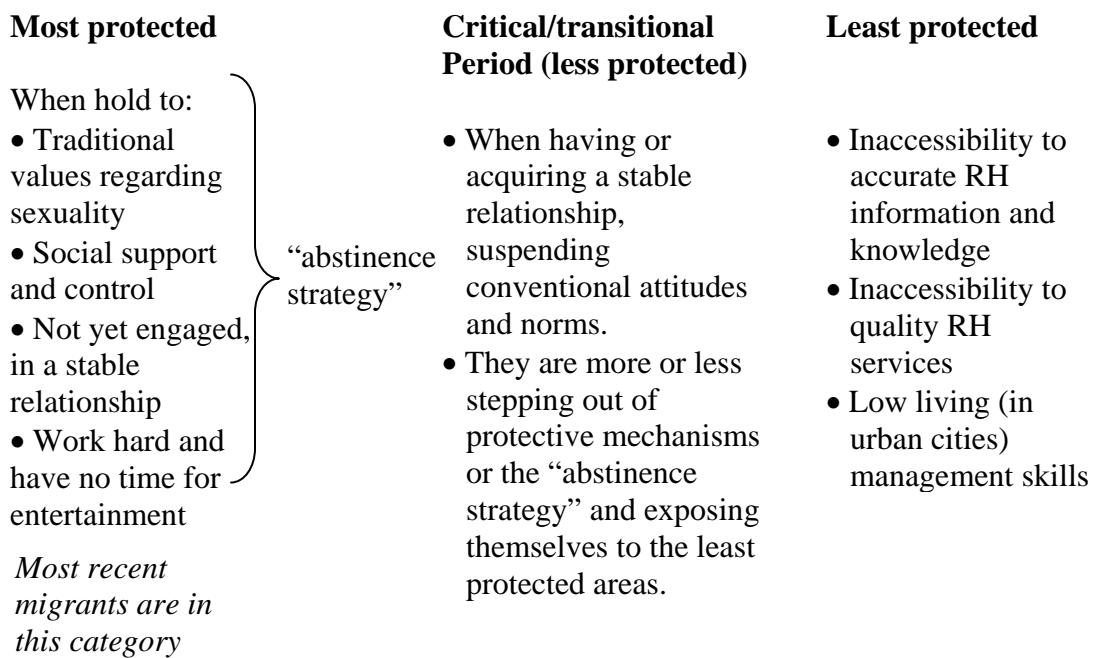
2. Traditional social values make single, female adolescents shy away from seeking information and services on sexual and reproductive health.
3. As for unmarried adolescent migrants, reproductive health information, knowledge and services target married couples only. Thus, they are not eligible and poorly informed.
4. Responsibility related to reproductive health is divided based on gender norms and roles. Pregnancy and abortion fall under the responsibility of women, as they are responsible for carrying the pregnancy, while disease prevention falls under the responsibility of men. Responsibility, moreover, is focuses on the individual level—belonging either to the man or the woman—rather than joint responsibility. As a result, the concept of jointly protecting one's own health *as well as* their partner's health does not exist.
5. Although their knowledge of reproductive health is limited, adolescent migrants in the four countries know more about family planning than HIV/AIDS, and they know more about HIV/AIDS than STIs, for which they know the least, if anything at all. This includes knowledge of STI transmission, prevention and treatment. Some of them do not know that women can contract STIs, and that they are at risk of HIV transmission (Boonstra, 2004; Reynold SJ et al. ,2006).

Most of the adolescent migrants lack access to quality reproductive health services due to several major barriers both at macro- and micro-levels. Macro-level factors center on a lack of clear-cut national health policies for adolescents, and for migrants, in particular; a registration system that influences the existence or coverage of social and health insurance schemes (to cover treatment costs); as well as gender norms and practices that support a sexual double standard and gender inequality that restrict the ability of women to communicate with their partners and negotiate safe sex (WHO, 2006b).

At the micro-level, the barriers include the poor attitudes and unfriendliness of service providers, the perceived fear of treatment and transportation costs, inconvenient service times, and, most significantly, a lack of privacy and confidentiality. Poor management skills in terms of living (e.g., poor communication skills, an inability to find moral support and adequate information, complicated procedures) also play a significant role in hindering the ability of adolescent migrants to access and use reproductive health information and quality services.

Consequently, analysis of the data from four participating countries presents a mixed picture of protection and risks among adolescent migrants (Figure 2).

Figure 2. Hypothetical levels of protection in relation to reproductive health risks among adolescent migrants in four participating countries



POTENTIAL AREAS FOR FUTURE ACTIVITIES

When and Where?

Activities that would equip young adolescents to protect themselves should cover two significant periods: before migration and after migration.

Before Migration. An analysis of the data indicates two main points that need to be taken into consideration: a) the information and knowledge about reproductive health and its risks that adolescent migrants receive in their communities of origin are incomplete or inaccurate; and b) adolescent migrants do not think that the information is targeted at them. Consequently, adolescent migrants must be prepared well before they migrate, and the best time is when they are about to complete their compulsory education.

The activities can be done at schools, in their communities (such as at community health or social centers), as well as through the mass media. The aim is to prepare the young people concerning their future work situation (job availability, realistic income expectations), living conditions, and the formation of relationships (“loving”) with special attention regarding reproductive health practices, risks and prevention

strategies in their new urban environment. Activities should be tailored in such a way that they make young adolescents understand and believe that the information and knowledge provided to them is specifically *for* them.

After Migration. Moving to an unfamiliar environment, being young and being impressionable, the migrants in this study were vulnerable in many ways. Many became dissatisfied and disheartened with their move. At the same time, they became caught up in everyday life to the extent that many of them felt that they would not return to their home communities, and were considering bringing their families to live with them in the city.

Although it could be assumed that adolescent migrants have better access to reproductive information in cities, the fact is that they are poorly informed. Activities to provide accurate reproductive health information, knowledge and services are vitally needed at this period of time. The activities or programmes could be organized at workplaces, such as factories or companies, in the communities or dormitories where adolescent migrants cluster, in learning centers, at shopping malls, at sporting events, at the health facilities and through the mass media. These programmes could be organized by reproductive health service providers or, better yet, through peer education.

Areas for Improvement

The lived experiences of adolescent migrants in the four participating countries suggest five major areas that are critically needed.

Once adolescent migrants start having a stable relationship, there is a tendency to suspend the prevailing attitudes and norms that previously served as a safeguard against sexual and behavior risks. The adolescent migrants are poorly informed about the consequences of unprotected sex, especially in terms of unplanned pregnancy, abortion-related complications, as well as STI and HIV/AIDS infection, transmission and prevention. Certain groups (e.g., female adolescent migrants in China and Lao PDR.) show more concern for unplanned pregnancy than contracting diseases. Consequently, this is the time when reproductive health interventions are most critically needed.

The empirical data revealed that prevention of pregnancy and abortion seem to fall on women's shoulders, while disease prevention is the responsibility of men. In either case, prevention is also perceived as an individual responsibility, rather than being the joint responsibility of both partners, and is fuelled by prevailing gender norms and roles. Consequently, intervention activities need to tackle the divided role of prevention between men and women, and draw attention to collaborative prevention among the couples, as well as other family members, for the benefit of all.

Reproductive health information and education interventions should include, at least:

- information and knowledge on contraceptive methods;
- information and knowledge on the consequences of unprotected sex in relation to unplanned pregnancy, abortion and its complications, STIs and HIV/AIDS;
- on the relationships between STIs and HIV/AIDS; and
- information and knowledge on transmission, prevention and treatment of STIs and HIV/AIDS.

As for accessibility to quality reproductive health services, social, cultural, and psychological barriers exist in many forms. Though accessibility is a major factor, findings indicate that other important considerations must be taken into account, and these may even play a more important role than access. These factors include convenience, cost, professionalism, confidentiality, privacy, coverage by insurance scheme, as well as familiarity with health services and providers. All of these must be taken into account in planning and implementing reproductive health services for adolescent migrants and *with* adolescent migrants.

Living management skills. This is another area that is needed along with attractive programmes providing reproductive health information, knowledge and quality services. Living management skills include competency in communication, searching for social networks, finding moral and information support, and dealing with the complicated procedures of reproductive health services. This skill will facilitate the adolescent migrants in accessing and using reproductive health information, knowledge and quality services.

Groups Needing Special Attention

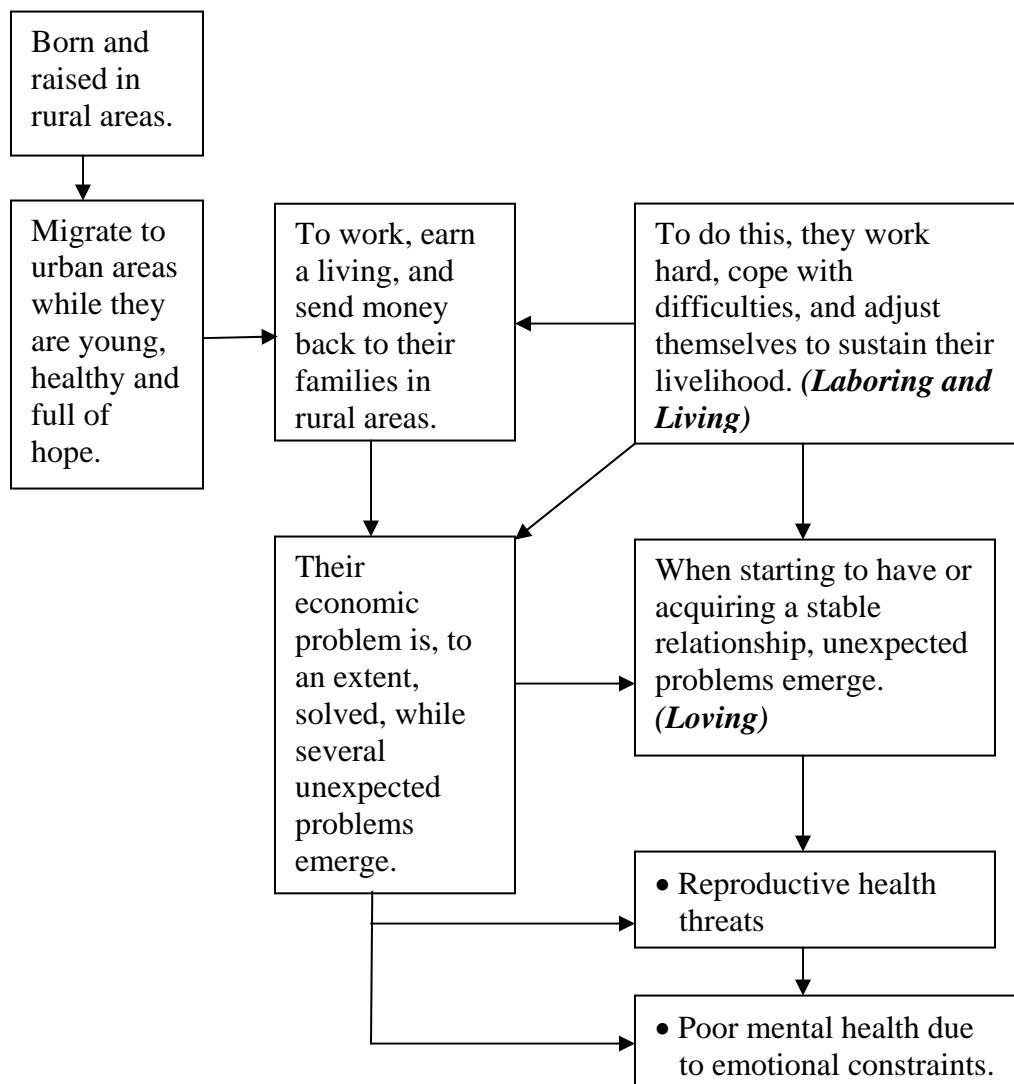
Not surprisingly, the most at-risk group requiring special attention is adolescent migrants who are not covered by national social and health insurance schemes. This includes unmarried men and women, married adult men, cross-border migrants (commuters), children of construction workers, and the children of migrants. They are the neglected groups and have the least access to reproductive health information, knowledge and quality services.

SUSTAINING LIVELIHOOD

Before migrating, the adolescents viewed cities as modern, prosperous places where opportunities abound and where their hopes and dreams can come true. After

moving and living in urban cities, they soon realize that behind the beautiful urban curtain, there is also a rough road that they must travel. Life is hard in big cities. They are faced with many trials, such as finding jobs, dealing with the cost of living, finding affordable housing and transportation, dealing with feelings of loneliness, seeking health care, and effectively communicating with others. No matter how hard city life can be, however, the adolescents soon have no intention of going back to their old homes; the city has become their new home. Their ability to cope with difficulties, adjust themselves to a new lifestyle, and work hard to keep their dreams alive soon make them an indelible part of their new urban life and the livelihood they have come to know and sustain.

Figure 3. Livelihood of the adolescent migrants



Their livelihood will be successfully sustained if they can cope with economic as well as other emerging problems, most notably, reproductive health risks. Programs to assist adolescent migrants in protecting themselves against reproductive health threats should be an integrated package covering the three major aspects of their livelihood: laboring, living and loving. The data also indicate that the mental health of adolescent migrants needs to be investigated further for effective program actions.

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This publication reports qualitative findings from a multi-country study on the reproductive health of adolescent migrants. Conducted by distinguished organizations in China, Lao PDR, Thailand and Vietnam, it presents the plight of rural adolescent migrants as they live, labor and love in their new, more liberal urban settings, and how they mediate between their lives in the city and their prior, more conservative lives in their rural home communities.

Collectively, the studies reported herein reveal that the desire to escape poverty and to improve their lives and the lives of their families are paramount reasons for migration. Though they have left their rural homes, and some do not intend to return, the migrants are not alone. Social networks stretching from their rural communities into their new urban homes provide the adolescents with some protection against reproductive health risks. Yet, these networks are inadequate, as they may just as easily provide incorrect reproductive health information. For those young women and men who succumb to reproductive health threats, either due to lack of knowledge or prevailing gender norms and inequalities, their journey through the reproductive health service system abounds with barriers to access and utilization as the young migrants spend valuable time and money trying to receive treatment, often from unfriendly service providers.

Much needs to be done to better equip adolescent migrants in the Greater Mekong Sub-region to protect themselves from reproductive health threats. This publication suggests many interventions designed to fit the needs and constraints of adolescent migrants in China, Lao PDR, Thailand and Vietnam, and possibly other country settings as well.