Sexuality, Reproductive Health and Violence:

Experiences of Migrants from Burma in Thailand

by
Therese Caouette
Kritaya Archavanitkul
Hnin Hnin Pyne

Institute for Population and Social Research,
Mahidol University

Sexuality, Reproductive Health and Violence:

Experiences of Migrants from Burma in Thailand

by
Therese Caouette
Kritaya Archavanitkul
Hnin Hnin Pyne

Institute for Population and Social Research,
Mahidol University at Salaya
Puttamonthon 4 Road,
Nakhonprathom 73170 Thailand

This study was funded by Ford Foundation
and the Norwegian Government
via the Asia Technical Department of the World Bank

Published with support from Ford Foundation
and William and Flora Foundation

Sexuality, Reproductive Health and Violence:
Experiences of Migrants from Burma in Thailand

Therese Caouette
Kritaya Archavanitkul
Hnin Hnin Pyne

First Published: June 2000 / 1,000 copies

Library Congress Cataloging in Publication Data

Caouette, Therese
Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand / by Therese Caouette, Kritaya Archavanitkul, and Hnin Hnin Pyne
(Institute for Population and Social Research, Mahidol University,
IPSR Publication Number 247)

ISBN 974-663-656-1

1. Foreign labor, Burma-Thailand-Health aspects. 2. Hygiene, Sexual. 3. Human reproduction-Health aspects. I. Kritaya Archavanitkul. II. Hnin Hnin Pyne. III. Mahidol University. Institute for Population and Social Research. IV. Series.

HD6300 C235A 2000

Design by : Watchara Ritmahun
Tel. 735-9518-9, 01-697-7694
Published by: Institute for Population and Social Research
Mahidol University
Puttamonthon 4 Road, Salaya,
Nakhonprathom 73170
Thailand
Telephone: 66 2 441 0201-4, 441-9666
Fax: 66 2 441-9333
E-mail: directpr@mahidol.ac.th
Website: http://www.mahidol.ac.th/mahidol/pr/pr.html

Contents

Contents

List of Figures

Foreword

The Institute for Population and Social Research (IPSR) at Mahidol University has been a leader in research on international migration. From 1995 to 1997, IPSR conducted a large-scale project examining all forms of population movement into Thailand. The results of this project have been influential in formulating migration policy in Thailand. In 1998-1999, IPSR has broadened its scope of work to include regional aspects of international migration. Activities in this area are reflected in publications and in organizing a regional policy workshop in May 1998 and producing a discussion paper on 'Managing the Flow of Migration : Regional Approaches' for the international conference held in Thailand in April 1999.

This book deals with an important issue on undocumented migration from Burma to Thailand. IPSR has started to look at this movement since 1995. Previous work of IPSR on undocumented migration from neighboring countries examined general situation of migrant workers and their impacts on Thai society. The issues investigated in this report are an extension of previous work on migrants from Burma. The report focuses heavily upon life experiences of migrants on sexuality, reproductive health and violence. Both quantitative and qualitative approaches were employed in this study. The latter approach allows migrants to voice in their own words on their perception, concerns and needs. This makes the report more vivid and attractive.

Undocumented migration is now on the rise within Asian region and becomes a problem of many countries, including Thailand. Research is required to understand consequences of the move on migrants' life as well as impacts of this movement on both countries of origin and destination. Mahidol University is committed to undertaking research that would lead to policy development and which has the potential to improve the quality of life of individuals. I feel that this book contributes to both on these aims.

Professor Dr. Pornchai Matangkasombut,
President of Mahidol University

Preface

Increasing migration between countries throughout Asia has raised a wide-range of critical and complex issues. Little is known about the impact of migration and inter-relatedness of issues as perceived by the migrants themselves and how these determine their responses. Sexuality and reproductive health issues are one area where the lack of knowledge and insight into the migrant's perspectives, concerns and realities in the larger context of their lives severely limits the ability to reach out to the needs of the individuals and their communities.

The massive influx of migrants from Burma into Thailand is one of the largest migrant populations in Southeast Asia. The migrants from Burma are an ethnically diverse population coming from all over the country and speaking many different languages, often lacking a common one among themselves. This study has focused on three provinces in Thailand (Chiangmai, Ranong and Samutsakhon) with large and diverse migrant communities. Though the findings cannot easily be expanded to describe the broader migrant population from Burma in Thailand, it clearly provides critical similarities and correlations that need to be considered when working with migrant populations in general.

The extent to which issues of violence and safety strongly determine migrant's perceived choices and decision making emerged consistently throughout the study. The increasing frequency and incidences of violence encountered in their country of origin, country of destination, communities and homes are critical factors in every migrant's life and has a direct impact on all aspects of their health, including reproductive health. It is in understanding their fears, vulnerabilities and realities that effective and collaborative responses to their situation (and those in their communities) can be found.

This report has identified collaboration between the Government, NGOs, and other community groups as being essential in providing comprehensive policies and interventions to better management of migrants, social status of migrants and health care services for migrants. It is anticipated that collaborative work among policy makers, government officials, NGOs, academics and civil society on this issue will ultimately produce policies and plans that are both humane and effective. Finally, we hope that lessons learned in this study can be used to improve the well-being of all - Thais and non-Thais.

Bencha Yoddumnern-Attig

Dr. Bencha Yoddumnern-Attig,
Director of the Institute for Population and Social Research

Acknowledgments

The migrant communities from Burma in Thailand are a rich and diverse population that have brought more to the individual researchers than we will ever, unfortunately, be able to give back in return. In understanding the many complicated and compounding factors that impact on their day to day lives it is with a sense of overwhelming awe at how they manage not only to survive but keep their spirits and willingness to open to others. It is the hope of all those who conducted this study that we could give back to the migrants and their communities some of the respect that they shared with us and advocate for interventions that respond to their concerns and realities.

One of the exciting components of this study was the opportunity to work together with migrants from Burma in Thailand to learn from one another and develop together this study and its implementation. The Project Director Dr. Kritaya Archavanitkul and Principal Investigators: Therese Caouette (Chiangmai), Hnin Hnin Pyne (Ranong) and Pornsuk Koetsawang (Mahachai) worked together with many members of these communities to help conceptualize the issues, provide background information, introductions, data collection, transcribing, translation and discussion of the findings. It is only with their collaboration and support that this study was possible. Particular thanks and admiration for all the hard work and the wide range of skills of the field researchers is most crucial. Their names are as follow:

In Chiangmai: Mo Ngun Hom Kampang, Hseng Oo Longhtun, Yawong Khampang, Charlie Po Harn, Kong Lung Mong and Long Koh Fah;

In Ranong: Mi Te, Lwin Lwin Oo, Myo Myo, Paing Soe Oo, Nelson and Win Latt. In addition there were many others in these communities whose direct support and skills added a great deal to the success and safety of this research. These include Kham Han Fa, Hseng Noung Lintner, Dr. Naing, Dr. Kyaw Thet, Awin, Than Htay, Min Kyaw Htun, Badar, Tukata, Thet Naing, Tint Lwin, Mommy, Thawta Aung, Simon and Soe Moe.

In Mahachai: Nyi Nyi Lwin and Hseng Muay (who joined the Chiangmai team for the second phase of the research);

There were many others whose efforts on a day to day basis made the implementation of the many aspects of this project possible and we are most grateful for their contributions. These include many of the Non-governmental Organizations (NGO's) in these three communities who continue to reach out to the needs of migrant workers in a variety of ways and are the lifeline for so many.

The authors would like to express our deep appreciation to the Institute of Population and Social Research at Mahidol University for taking on this project and offering their very committed staff supports to this project. Without this support, the project would have never gotten off the ground. Our extremely special thanks go to IPSR Director, Dr. Bencha Yoddumnern-Attig, IPSR Secretary, Orapan Hunchangsit, and IPSR Research Accountant, Jutakarn Atithananun. In particular, much gratitude and respect goes to our research associates: Wanna Jarusomboon and Wanee Pinprateep. Without their coordination among three research teams, it is almost impossible to conduct this study smoothly as it was. We also would like to add a special thank to Kanokwan Tharawan for her excellent training on sexuality, reproductive health and rights.

Dr. Lisa Keary spent endless hours with the meticulous editing of this report which included translations and cultural references from three ethnic populations. The flow of this report, without compromising the nuances and complexities, is the result of her patience and careful work.

Last but not least, this research would not have been possible without the ability of the donors to understand the importance of the issues addressed in this study and participatory approach to research. The grant and input from Ford Foundation and financial support from the Norwegian Government (administered by the Asia Technical Department of the World Bank) made the many aspects of this study and its dissemination a reality. Our acknowledgment is also extended to the William and Flora Hewlett Foundation for partially support in publishing this report.

Therese Caouette
Kritaya Archavanitkul
Hnin Hnin Pyne
July 2000

Abstract

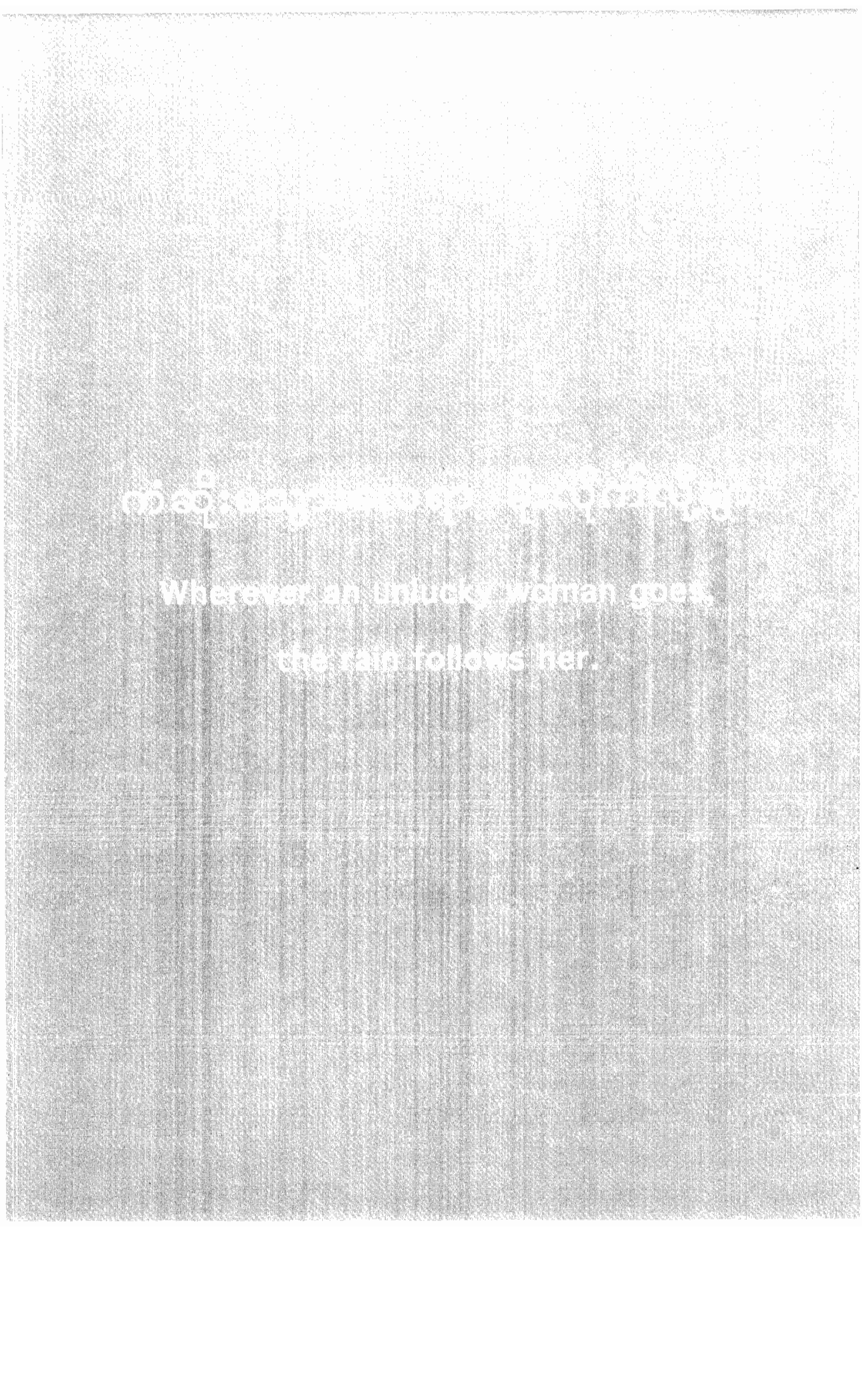
Over one million migrants from Burma are currently residing in Thailand. The migrants are an ethnically diverse population coming from all over Burma and speaking many different languages. What they all share are encounters of fear and/or violence which affect most every aspect of their lives.

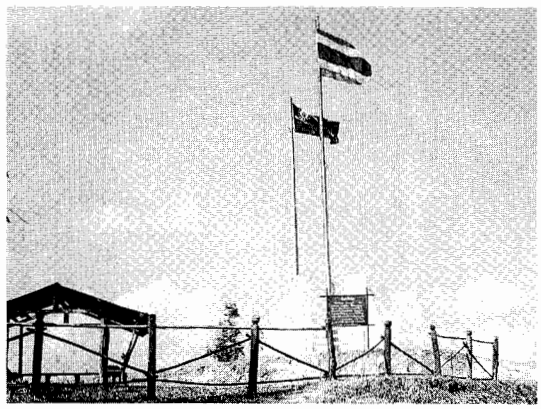
Violence throughout the lives of the migrants interviewed was a critical factor in the research findings and directly impacted on their health and care-seeking behavior. In Burma, a wide range of State abuses were reported with some encounters of violence by opposition or minority factions noted. Violence encountered in Thailand was largely due to the illegal status of migrants and government crackdowns. In addition, abuses by employers or at the workplace were extensive. Sexual violence and other abuses in the community were also common, particularly among female participants.

The majority of migrants were unable to seek or negotiate appropriate health care services due to their illegal status (fear of arrest, detention and deportation), lack of funds and Thai language skills. Migrants typically treated themselves and bore the illness as long as possible on one's own. Consequently, there were considerable numbers of death reported among migrants from Burma in Thailand, often for treatable health problems. The most common causes of death were maternal mortality, malaria and work place injuries.

The fear of violence, much stronger among female migrants, resulted in solitary and confined lives at their place of employment or nearby residence. All these factors hinder the ability of female migrants to claim their basic rights in the family, community, work place and society as a whole and limit their ability to address and learn about their sexual and reproductive health.

Active steps must be taken to respect and protect the human rights of peoples from Burma both in their home country and abroad. Thai government policies must be developed with a framework for implementation that includes input and responsibilites from officials at both the national and provincial levels. These responses should recognize migrant workers AND their families. Inclusion of the migrant community in developing these responses would improve their effectiveness. At least, translation of the policies and procedures related to migrants should be made available in their language and actively distributed.





This study's aim is to document
the perceptions, concerns, and realities
of female migrants from Burma
who live in Thailand to better understand
their lives and reproductive health concerns.
It also includes the voices of others,
particularly those of male migrants
as well as employers, government officials,
and service providers.

Chapter 1
Introduction

1.1 Background

Massive migration within Burma[1] and into neighboring countries has increased in the past decade. Estimates of as many as five million migrants[2] have moved within and out of Burma in the past ten years.[3] This estimate is based on data collected by a wide range of non-governmental sources, since official data is either unavailable or extremely limited. By 1990, 1.5 million people in Burma had been affected by the government's 'resettlement programs', and since then an estimated additional one to one and a half million more have been relocated (Venkatesvaran, 1996; Smith, 1996). Furthermore, it is estimated that there are more than one million internally displaced minorities within the country (Smith, 1996). In Thailand, over 100,000 refugees from Burma are residing in camps (Human Rights Watch, 1997a) and at least 800,000 are working as illegal migrants (Archavanitkul and Koetsawang, 1997). By 1992, 250,000 people from the Arakan State in Burma crossed into Bangladesh (Human Rights Watch, 1997b) and, although nearly 190,000 have been repatriated, many were not able to return to their original homes. Approximately 140,000 refugees and displaced persons are living along or across the China border (Smith, 1996), and there are also reports of massive

1 The term "Burma" is used throughout this report as this is the term used by migrants and in the Thai language though it is recognized that the country's official name has been changed to Myanmar.

2 The term "migrant" in this report refers to all people who move out of their homes for an extended period of time. The report does not distinguish among "migrants" by reason of their relocation. The term "migrant," therefore, includes internally displaced persons, refugees and migrant workers or traders.

3 This estimate includes over ten percent of the population based on a total population of 44 million, which was documented by the Department of Immigration and Manpower of Myanmar in 1995, based on the 1983 national census.

relocations along India's border, with over 40,000 living in camps (Images Asia, 1998). Burma has also in recent years experienced mass economic migration to border areas for trading, gem mining and other jobs. This is in addition to the ongoing rural to urban migration that has been taking place throughout Asia for some time.

Growing economies, a strengthening of political and economic ties between the countries, and improved infrastructure have increased the permeability of national borders (Asian Research Center for Migration, 1995; Asian Research Center for Migration, 1997). Currently, approximately one million migrants from Burma reside in Thailand (Archavanitkul, 1998; Human Rights Watch, 1997). These migrants represent an ethnically diverse population. They come from all over Burma, speak many different languages, and are culturally and linguistically distinct from their Thai neighbors. These migrants typically reside in Thailand illegally and take low paying jobs that Thai nationals do not fill. They receive little or no health care services and not much attention has been given to their reproductive health needs. However, this is beginning to change as HIV infection rates among the migrant population within and from Burma are proving to be some of the highest in the region (Porter, 1995).

The vulnerability of migrants in general, due to their disruption, cultural differences and economic difficulties, has increasingly received international attention that has included a growing awareness to their reproductive health needs.[4] Critical reproductive health issues among migrant populations have been identified as (1) contraceptive access and use, (2) risk of HIV/AIDS and other reproductive tract infections, (3) safe motherhood, (4) unsafe abortions, and (5) violence against women (Population Report, 1996). However, it is unclear how these issues specifically affect migrant populations within and from Burma, as limited information is available on their lives, perspectives, concerns and realities.

The available gender-specific research on reproductive health among girls and women from Burma has been largely limited to either that undertaken in Burma itself or among female migrants from Burma involved in prostitution. Reproductive health research within Burma has begun to highlight the perspectives, concerns, and realities faced by married women of reproductive age (World Health Organization, 1997). However, a review of the literature coming out of Burma (published and unpublished) fails to document the impact of migration on reproductive health. Neither does it address the realities in many minority areas nor take into account the entire reproductive health cycle of females from birth to death (Smith, 1996). Studies on migrants from Burma have predominantly focused on fishermen and sex workers, often viewed as 'high risk groups,' however, the available research on sex workers from Burma in Thailand provides little insight into their reproductive health perspectives, though concerns of high rates of HIV/AIDS infection and non-consensual reproductive health interventions have been reported (Archavanitkul and Koetsawang, 1997; Pollock, 1996; Asia Watch, 1993; Pyne, 1992).

4 Migration has been recognized by the United Nations Commission on Population and Development (1996) as one of four sensitive issues urgently requiring the attention of the international community.

Recently, several assessments were conducted on the general health situation of migrant workers from Burma who have crossed over the Thai border. Towns in areas such as Ranong Province in the South and the Maesai District of Chiangrai Province in the North have received relatively more attention both in research and interventions. The studies conducted commonly have employed methods such as knowledge and behavior surveys and rapid assessment techniques, which include observation and interviews with key informants, including provincial health authorities, hospitals, and NGOs (Oppenheimer, 1997; Shakti, 1997). Overall, the studies have not included many of the major industries that employ women and men from Burma. Female migrants from Burma face greater difficulties, as they typically work in unrecognized labor sectors (such as domestic service, other service sectors or as mothers or housewives). They are usually paid less than men and face different concerns and needs (Archavanitkul and others, 1997). These women have little or no opportunities to receive health education or services, and their reproductive health care has largely gone unaddressed. In addition, many girls and women from Burma come from rural or minority areas where reproductive health education or services are under-developed or non-existent (Smith, 1996). Consequently, female migrants from Burma are further limited in their ability to draw on their own or their community's knowledge base in addressing their reproductive health concerns. Finally, research has failed to elucidate the concerns and problems as perceived by the migrant workers themselves, or to consider gender and ethnic differences in their experiences.

In addition, the limited research that has focused on the reproductive health of migrants in Thailand, particularly those from Burma, has failed to consider the larger economic and social contexts and relations in which sexual behaviors and risk are embedded. The ability of girls and women to address their own reproductive health concerns is directly influenced by the broader context of their lives and the ability to which they are able to exercise their basic human rights (Mann and Gruskin, 1995; Sen, Germain, and Chen, 1994). From the information available, female migrants from Burma report living in extremely abusive environments with high incidences of drug use, sexual harassment, and physical and sexual violence. In addition, female migrants from Burma have received little or no information or services given their isolated and often illegal status. The high rates of HIV/AIDS infection found among the migrant community highlights a wider range of health problems in general and reproductive health needs in particular.

The public health community has expressed grave concern about cross-border movement because this form of migration poses an additional set of issues and concerns related to citizenship, legal rights, and access to services and support, and thus, presents a true challenge for those designing policy and program interventions. Those addressing issues around migration and HIV/AIDS have increasingly brought public attention to these issues. There is a critical need for research that explores the wide range of issues, experiences, and perspectives of migrants in order to determine policies and interventions that are most appropriate in addressing their HIV/AIDS risks and other specific reproductive health needs.

The Thai Government is continually being asked to address the presence and human rights of undocumented migrant workers in its country, of which those from Burma make up the largest proportion.[5] In addition, as migrants become increasingly integrated into the local communities where they reside pressure is mounting to address their health needs, especially related to communicable illnesses. Finally, growing migrant populations have health needs that are heavily impacting health care systems, particularly in the areas where they reside in large numbers. Understanding how migrant populations address their health needs could facilitate more effective support to policy makers, local communities, health care systems and the migrants themselves.

1.2 Objectives

This study's aim is to document the perceptions, concerns, and realities of female migrants from Burma who live in Thailand to better understand their lives and reproductive health concerns. It also includes the voices of others, particularly those of male migrants as well as employers, government officials, and service providers. The study reflects a represen tation of the migrants from Burma who have entered who reside in these three sites (Chiangmai, Mahachai and Ranong) in Thailand since 1988. This study does not distinguish between the voluntary or involuntary nature of those who migrate or the extent of their mobility.

1.2.1. The primary goals of this study are:

(1) To identify structural, relational, and individual constraints on opportunities to improve repro ductive/sexual health of and prevent violence against female migrant workers from Burma
   - structural (e.g., national policies, legal status, regional politics and work orga nizations)
   - relational (e.g., gender relations, employer-employee and service provider-client relations)
   - individual (e.g., beliefs, attitudes and behaviors)

(2) To recommend intervention strategies (e.g., communication campaigns and service provisions) at the structural, relational, and individual levels

(3) To identify questions and areas for further research

In order to achieve the above-stated goals, the study was conducted in two phases. The objectives of each phase are described below.

5 Numerous conferences and consultations have been held with the Thai Government and other governments in the region to address the realities of migrant workers moving into, out from, and through their countries. The health status of migrants, their vulnerabilities, and the impact on host country populations and health systems have been discussed in many of these forums.

1.2.2 Phase One Objectives

(1) Identify reproductive/sexual health beliefs and concerns of fe male migrant work ers, including
   a) current belief systems and terminology, and
   b) perceived causes of reproductive and sexual health problems
(2) Describe care-seeking behaviors, including
   a) the extent to which female migrants seek care for experiences of reproductive/ sexual health problems and violence (e.g., where, when and from whom)
(3) Describe social norms on reproduction, sexuality, and violence (both female and male migrants), including
   a) reproductive issues (e.g., pregnancy and motherhood, con traception, abortion, and reproductive decision making),
   b) sexual issues (e.g., virginity, premarital sex, extramarital sex, commercial sex, and sexual decision making), and
   c) violence (e.g., sexual coercion, physical abuse, and domestic violence)
(4) Describe perceptions of community members and influential others on female reproductive/ sexual health and violence, including those of
   a) male migrant workers
   b) health care providers (traditional healers, health officials, private clinics)
   c) employers
   d) government officials

1.2.3 Phase Two Objectives

(1) Describe the effects of migration on personal networks of female migrant workers, including
   a) residential network(s) ('whom do you live with')
   b) work network(s) ('who do you work with')
   c) social support network(s)
   (emotional, informational, and instrumental related to repro ductive/sexual health and violence)
   d) communication network(s) ('with whom do you discuss reproductive/sexual health issues')
(2) Assess the influence of personal networks maintained in Thailand on reproductive and sexual health care, support-seeking behaviors, and exposure to violence

1.3 Research Design

The Institute for Population and Social Research (IPSR), Mahidol University conducted this study in 1998. The study's research team was comprised of a project leader and three investigators, each of whom employed two or three research assistants that were primarily involved with data collection and management at each study site. The assistants were fluent in the languages of the target population and were migrants themselves. Three workshops among

the research team were organized throughout the study. The first workshop focused on key aspects of the research: reproductive health concepts, ethics of conducting social science research, conducting in-depth interviews, facilitating focus group discussions, and addressing ethical issues involved in studying illegal populations (such as ensuring confidentiality and safety). The interview guidelines[6] were field tested and revised during the training with agreed upon probe and follow-up questions. The second workshop emphasized understanding the differences between qualitative and quantitative data collection methods and sampling strategies, and also included discussion on how to conduct structured interviews. The third workshop concentrated on data coding, data entry, and data cleaning.

As earlier noted, the study was undertaken in two phases. Phase One employed qualitative research tools to gather a narrative background on the definitions, language, and perceptions of reproductive health by the targeted migrant population. Three qualitative tools were used during Phase One to provide triangulation of the data. These techniques included observation, in-depth interviews, and focus group discussions. The formative period of Phase One was late January to mid-April 1998, when the in-depth interviews and focus groups discussions were conducted.

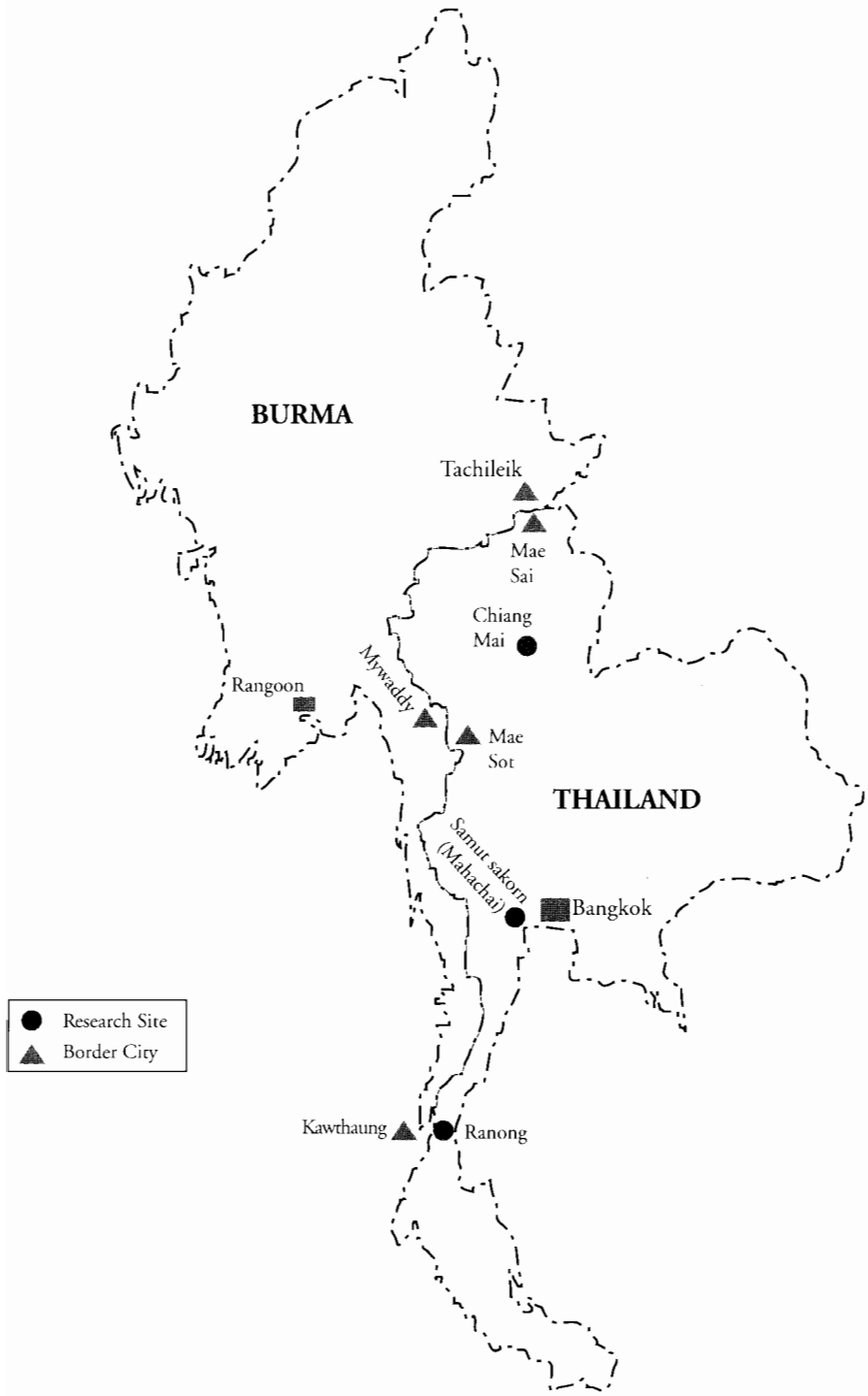
In Phase Two a structured questionnaire was employed. The data collected during Phase One was used to revise this research instrument in order to capture participants' reflections on issues raised in the in-depth interviews and focus group discussions, as well as the cultural context of the migrant populace. The survey covered a much larger number of participants, which allowed the data to be statistically analyzed. In addition, the survey gathered information on the networks of migrants and how migration has impacted on them. The survey was carried out from late May to July 1998.

1.3.1 Sampling Design and Participants

Three different sites in Thailand were selected: Chiangmai Province in the north, Mahachai District of Samutsakorn Province near Bangkok, and Ranong Province in the south (see Figure 1). Three dominant industries that employ migrants from Burma were included at each site: plantations, sawmills, and fish processing plants in Ranong; the fish processing, manufacturing, and service industries8 in Mahachai, and the construction, manufacturing, and service industries in Chiangmai. Each of the study sites represented different ethnic groups and migratory routes. The sites and types of employment were purposively selected based on Thai government statistics of registered migrant workers in 1996. The three sites were also selected because they possessed an existing infrastructure of health care providers and non-governmental organizations that provide health care services. The established work and knowledge of local organizations, such as World Vision in Ranong, the Thai Action Committee for Democracy in Burma in Mahachai, and the Migrant Assistance Program in Chiangmai, provided the research teams with access to migrant workers' communities

6 The service industry includes those working in small shops, restaurants, gas stations and domestic environments.

Figure 1 :
The Three Research Sites and Major Border Cities along Thai-Burma Border



and guided the selection of key informants. It also enabled the researchers to foster rapport with and garner trust from the migrants.

The study limited the selection of migrant workers to a reproductive age range of 15 to 50 years old in order to highlight current reproductive health perspectives, concerns, and needs. This age range also reflects the most productive period in an individual's life and encompasses the majority of the migrant worker population. Another criteria, for determining the population sample, was the length of stay in Thailand. A period of ten years or less was chosen since a longer time period may have impeded participants' ability to recall details about social ties and conditions in Burma. More importantly, the year 1988 serves as a powerful reference point because it signifies a time of dramatic political events and change in Burma. Significantly, an exodus of people from Burma to Thailand occurred after pro-democracy uprisings erupted protesting the military leadership of the State Law and Order Restoration Committee (SLORC), currently known as State Peace and Democracy Committee (SPDC). These protests, as well as a steady stream of migration, have continued over the past decade. To sum up, criteria to determine the population sample in this study were as follow:

- female and male migrants from three different work site communities;
- individuals between the ages of 15-50;
- those self-reporting themselves as from Burma and not possessing a Thai ID card; and
- those who left Burma for the first time in or after 1988.

1.3.2 Data Collection Methods

The research tools used in Phases One and Two of this study are described in detail below.

(a) Observations: During Phase One, the research teams drew maps of the migrant workers' communities and wrote observation notes of the conditions and situations found at each of the work sites. These notes were later translated and compiled to describe the sites in which interviews took place. The teams concentrated on understanding the layout of each community (how residential units and work places are organized, points of transportation, local health resources, etc.), environmental conditions (sanitation and sources of water), and social environ (the employer and relationships between the workers). Observation exercises were undertaken throughout the entire research period, as new sites were encountered and communities relocated.

(b) In-depth Interviews: Semi-structured in-depth interviews were conducted that offered a degree of flexibility to probe and explore unexpected and often undocumented issues, but at the same time allowed for consistency between the three sites. The gender ratio of participants was two-thirds female and one-third male. In addition, health care providers, government officials, employers, community members and staff from various organizations in each area (referred to hereafter as key informants) were also interviewed.

The guidelines for the in-depth interviews were designed for gathering information from migrants, key informants, and service providers. The interview guide consisted of a written list of questions and topics specifying an order for how each inquiry should occur. The order of questions and topics was particularly important for this study because of the sensitivity and number of issues addressed (e.g., reproductive health, violence, care and support-seeking behavior). The interview guidelines were divided into six parts: (1) life in Burma; (2) migration; (3) work and life in Thailand; (4) reproductive and sexual health concerns; (5) sexual norms; and (6) safety and violence.[7]

Prior to all interviews, direct observation of the work sites was carried out. On subsequent site visits, the research assistants introduced themselves, explained their work, assured confidentiality, and requested an interview and permission to tape record the interview. Each interview took approximately one to two hours. The first part of each interview entailed listening to the participants' stories, their concerns and problems when they lived in Burma, their migratory journey to Thailand, and their experiences after arriving in Thailand. This helped to facilitate the discussion on sexual matters, which was taken up later in the interview. Rapport between the interviewers and the participants was also critical given the sensitive nature of the research questions. Since the interviewers were migrants themselves and were fluent in the language of the participants they were more easily able to establish rapport with them. The principle investigator and research assistants took notes during each interview, but primarily relied on the tape-recordings of the interviews, which were later transcribed into the language of the interview and then translated into English. In addition, the interviewers added their own comments separately at the conclusion of each interview to provide insight into the nonverbal communication and environs of the participants. The principle investigator worked together with the interviewers and research assistants to discuss their experiences, difficulties, and questions.

(c) Focus Group Discussions: The focus group method provided data on group interactions, which can enrich interview responses, particularly with regards to community norms and values. This method also permits flexibility and provides culturally appropriate language, which is critical since there is so little information about the targeted population. Moreover, it costs relatively less than other types of research methods (Krueger, 1994). Focus group discussions with migrant workers were used to (i) understand belief systems and language used in labeling and interpreting health problems; (ii) assess the communities' perceptions of reproductive well-being given other economic and safety issues; and (iii) identify health care concerns and issues and support-seeking behaviors.

For this research, the key focus group variables were identified as gender and ethnicity. Gender distinction was important owing to the sensitive and sexual nature of the topics and gender differences in discussing, experiencing, and interpreting issues of reproductive health.

7 The guidelines for the in-depth interviews were translated into the language of the participants, predominately Shan and Burmese. These translations were then translated back and pre-tested for accuracy in content and cultural interpretations.

Therefore, focus groups were carried out separately with male and female migrant workers. Ethnicity was the other criteria for determining focus group participants. This criteria was necessary to ensure that the participants spoke the same language and shared similar cultural backgrounds.

The size of the focus group was determined according to Krueger's (1994) guidelines which suggest that groups should be small enough to allow for every individual to have an opportunity to express their points of view, but large enough to achieve a diversity of views. For this particular study, six to eight people were the ideal size for each focus group discussion. This size of the group in this study was smaller than ideal and was necessary in order to ensure the safety and security of the participants. Larger groups would have attracted attention and created discomfort for employers, as well as participants. Initially, the focus group discussions were structured to include participants from each of the different work sites. However, due to security risks involved in taking workers outside of their workplace and residential compounds, discussions were only held among participants from the same site. It was critical that these individuals felt safe and comfortable enough to discuss their own personal experiences and concerns and that there were also no risks or danger associated with participation in these discussions for either the participants or the researchers.

The focus groups followed the same interview guidelines as the in-depth interviews and were conducted in the language of the participants, with facilitators of the same sex. The data from the focus group discussions were collected using a tape-based analysis strategy, which involved listening to the tape and preparing a brief written transcript (Krueger, 1994). In addition to comments from participants, this transcript included the moderator's and observer's comments, noting nonverbal communication, such as body language and level of energy. Taping allowed for the researchers to grasp the exact use of language and style of speech. The participants were assured that their remarks would remain anonymous and confidential, despite being taped.

Individuals who participated in the in-depth interviews or focus group discussions received a small gift of clothing, food or drinks, basic medicine for skin rashes, soap, or other personal needs. In some instances when immediate health care was requested, research assistants contacted health providers on behalf of the migrants while other referrals for information were provided following the completion of the interview or focus group discussion.

Three research teams carried out in-depth interviews with a total of 108 participants (62 female migrants, 37 male migrants, 9 key informants) and conducted a total of 39 focus group discussions with a total of 83 participants (see Table 1.1).

Table 1.1 Number of Participants According to Data Collection Method Used in Phase One

Research Tools In Phase One	Ranong		Chiangmai		Mahachai		Total	
	Women	Men	Women	Men	Women	Men	Women	Men
Key Informants	1	2	2	2	1	1	4	5
In-depth Interviews	21	13	31	10	10	14	62	37
Focus Group Discussions	7	10	15	5	1	1	23	16
Total for Phase I	29	25	48	17	12	16	89	58

(d) Structured Questionnaire: During Phase Two, a survey was used to expand the number of study participants and thereby provide a larger population sample for analysis. Data collected from Phase One was incorporated into the development of the survey, which included both open-ended and close-ended questions. The survey was translated from English into the local languages of the migrant populations at each site.[8] The first translations were back translated into English, corrections were made, and then field tested for context and cultural interpretations. Questions and wording were adapted to accommodate the language and grammatical preferences of the participants.

Due to arrests of undocumented migrants in the Mahachai area and the uncertain political situation during the launch of Phase Two of this study, no participants from Mahachai were surveyed for security reasons. Instead, the number of participants was increased at both the Chiangmai and Ranong sites in order to gather a statistically significant response rate. As mentioned earlier, the survey employed several different sampling strategies. The communities/work sites were not randomly chosen, but were selected based on their geographic location and pre-existing health care related organizations. At each site, participants were recruited employing systematic random sampling, simple random sampling, or snowball sampling. A systematic random sampling was used in communities where researchers were safe and familiar, able to move around and contact every household in the community. A simple random sampling was utilized in work or residential sites that were relatively small. The initials of every individual in the work place/community were written on small pieces of paper, which were then placed into a hat and pulled out randomly. The most commonly used strategy was snowball sampling, which began with a randomly selected respondent who then referred or introduced other individuals for the researchers to interview.

In Ranong, the survey participants were principally employed in three different industries: fish processing, sawmills, and rubber plantations. The fishery industry employed

8 The survey was translated into Shan and Burmese languages.

the largest number of Burmese migrants, followed closely by plantations and farms. Although no official estimate exists, key informants and local NGOs informed the researchers that the labor force in the sawmills was largely Burmese, primarily because the logs came from Burma. The survey participants in Ranong included 172 migrants from 15 fish processing communities, 145 migrants from seven sawmills, and 101 migrants from ten plantations.

In the city of Chiangmai, the construction industry employs more people from Burma than any other sector.[9] Chiangmai is the third largest city in Thailand and prospers from an extensive tourism industry that also provides employment for migrants from Burma in the manufacturing, retail and service sectors (e.g., cleaners, waiters/waitresses and gas attendants). Survey participants in Chiangmai included 229 migrants working on construction sites and 90 migrants employed in factories and service sector jobs.

In addition to the size of the migrant labor force, logistics such as access to and safety of the participants (as well as the researchers) were critical considerations in determining the type of employment and sample size at each site. The total number of participants surveyed during Phase Two of the study was 827, which included 418 from Ranong and 409 from Chiangmai. The actual breakdown of the participants by site, employment sector, and gender is shown in Table 1.2 below.

Table 1.2 Number of Participants in Phase Two According to Site, Employment Sector, and Gender

Sector of Employment		Women	Men	Total
Ranong	- fish processing	84	88	172
	- sawmills	78	67	145
	- plantation	57	44	101
Chiangmai	- small factories	41	49	90
	- construction	120	109	229
	- service industry	57	33	90
	Total	424	403	827

1.3.3 Data Analysis

Socio-demographic variables were collected for each respondent in the in-depth interviews and focus group discussions. These variables were identified in advance from the background section of the interview guidelines, and were entered into a spreadsheet format using the Excel Program.

9 The data on the number of migrants came from provincial labor offices before the full impact of the financial crisis was felt.

Ethnograph 4.0 was used to analyze the remaining data. This program requires that a code of categories be identified based on the objectives of the study, interview guidelines, and themes identified during the study. Each interview was transcribed by the research assistants, translated from Burmese and Shan into English, and typed into a word-processing program. These interviews were then entered into Ethnograph and each line of the text was numbered. The data was then coded by hand and re-entered into Ethnograph, which compiled the data under each code noting what interview was being quoted and in what other sections it had been referenced.

The observation notes and in-depth interviews with key informants and service providers were similarly transcribed, translated, and coded. This data was processed in Ethnograph separately in order to facilitate a process for cross-referencing the data and obtaining feedback from the participants during the analysis process.

The data collected from the survey conducted during Phase Two of the study was analyzed using the computer program SPSS 7.5 The data from each site was entered separately to facilitate comparative analysis. The survey moved beyond traditional survey methods to assess social ties using a personal-network data collection technique. That is, participants were asked to name up to three individuals in specific networks (residential and leisure) in Burma prior to their departure, as well as in Thailand. The participants provided demographic information on these network individuals, as well as relational characteristics, such as type of relationship, place where relationship was formed, and relational content (emotional, instrumental, and financial support).

1.4 Profile of the Research Sites

Chiangmai : Chiangmai is a northern Thai province and borders the Karenni and Shan States of Burma, which represent the majority of Burma's eastern region. Agriculture is the predominant industry in Chiangmai province, whereas in the city construction and service sector jobs prevail, due largely to an extensive tourism industry. Migrants from Burma entering Chiangmai typically come directly over the long and porous border, while some officially cross on day passes at Maesai (further north in Chiangrai Province), from where they often make their way further into Thailand. The majority of migrants from Burma working in the city of Chiangmai are of Shan ethnicity. The Shan spoken language and many aspects of its[10] culture are similar to that of northern Thailand, which also has an ethnic Shan population. As a result, it has been easier for migrants of Shan ethnicity to communicate and assimilate into Thailand compared to other migrants from Burma.

Mahachai : Mahachai, a port city of Samutsakorn Province, is an industrial area just outside of Bangkok. Many factories, predominantly fish processing plants, are located here. Mahachai is one of the major connecting points at which migrants from Burma cross into the

10 The term "Shan" is used in this report, but this ethnic population is also referred to as "Tai Yai."

Thai provinces of Tak, Kanchanaburi, and Ranong looking for employment or travel further within or out of Thailand. Communities of migrants from Burma in Mahachai are so crowded that one could easily mistake Mahachai for a border town rather than an industrial city situated near Bangkok. According to some Thai officials, Mahachai is home to the largest community of Burmese migrants on the Bangkok periphery (Archavanitkul, 1998). Most migrants are brought to Mahachai by agents who require fees for providing transport and locating employment. As a result, many migrants are in debt for the several months or up to a year after their arrival. The migrants from Burma who come to Mahachai represent a wide range of ethnic groups, often not sharing a common language among themselves.

Ranong: Ranong province borders the Tanas-sarim Division of southern Burma and is situated opposite Kawthaung, Burma's southern-most town, which historically has been a cross-border trading post. In Ranong, fishing or fishery-related jobs and rubber plantations are the dominant industries. Most migrants from Burma residing in Ranong entered Thailand from Kawthaung. Since 1988, following the pro-democracy protests, large numbers of people fled Burma into Thailand. Many stayed in the Ranong area. Migrants from Burma live in communities throughout the province while others traveled further into the interior looking for work. The majority of these individuals are Burman, followed by those of Mon and Tavoy ethnicity.

1.5 Limitations of the Study

While the limited number of study sites does not permit generalizations about the entire population of migrant workers from Burma living in Thailand, the study's findings do provide important information on the reproductive health needs and concerns of a critical segment of that community (e.g., women and ethnic minorities). This study also raises a number of key issues that should be acknowledged and addressed among the larger migrant populations. As was previously discussed, the study sites (Ranong, Mahachai, and Chiangmai) were purposively selected because they represent maximally different migratory routes and each have attracted distinctly different ethnic groups from Burma. In addition, the workers interviewed at each site represent the prominent industries that employ migrants from Burma.

One of the limitations of the research design was that the study was able to focus only on one side of the migration route, Thailand, and only at one point in time. It was not feasible to conduct a study within the original communities of the migrants, owing to the political sensitivity of cross-border migration in Burma, political instability, and the time and cost that would have been required. The researchers, therefore, had to rely on the participants to recall the nature of their personal networks and behaviors in Burma. In addition, the dynamic nature of the networks developed in Thailand could not be fully captured by a cross-sectional research design, without a corresponding longitudinal element. Rather than looking at the changing nature of networks, this study focused only on the social relationships maintained and/or established at a one particular point in time.

Security was a major obstacle for the research team as the vast majority of the migrants resided and worked illegally in Thailand. In early January 1998, the Thai government

instituted a policy of arrest and deportation of all illegal migrant workers, claiming that they were taking jobs away from Thai nationals. This policy had the effect of marginalizing the Burmese migrant community even further. There were reports of migrants encountering more arrests, extortion, robberies and abuses, and many migrants reported facing increased discrimination and abuse by Thai nationals, which led to escalating tensions in their communities. Since the migrant communities were unprotected and reports of violence were common, it was difficult for the investigators and research assistants to enter, continue, or return to the some areas. These factors also hindered, in many cases, the ability to establish the trust necessary to carry out the research.

Almost all of the female migrants were unwilling to meet outside of their rooms for security reasons, which made the interviews difficult to carry out since the migrants' residences offered little or no privacy. There were continuous distractions and interruptions during the interviews because the migrants' housing was made of tin and thin wood planks with walls approximately six feet high that did not reach to the roof. In general, the male migrants were more mobile, so that, in some cases, it was possible to conduct interviews in places that offered more privacy and fewer distractions.

Some of the migrant communities were extremely mobile often working on one site for only six weeks to three months before relocating to another work place. While some moved with the work, others lived in one place and were transported each day to various work sites. The economic turmoil caused by the Asian financial crisis slowed down and stopped many of the construction projects in Thailand, which resulted in the failure of employers to pay salaries, increased layoffs, and made it necessary to transport workers more extensively than ever before. As a result, nearly half of the migrants in Chiangmai and Mahachai began to leave during the period of data collection for this study. Many migrants told the researchers they were returning to the border or back to Burma. These factors made it difficult to establish contacts and develop the trust necessary to carry out the interviews. It also precluded the ability to return to many of the participants for follow-up interviews.

The study was conducted during the period leading up to the Water Festival (Traditional New Year) celebrated throughout Thailand and Burma. Seasonally, this is the time when most people (including migrants) try to go home to be with family and/or friends for the holiday. It is also the end of the dry season and an easy time to travel (especially along the border or in Burma) before the rainy season begins. However, to delay the study into the rainy season created many more obstacles for the research. Therefore, it was decided to try to work around this holiday.

Another obstacle to data collection was the exceptionally long hours the migrants worked each day. A typical day started at 7.30 a.m. and went until 6.00 p.m., with migrants eager to work overtime when offered. In addition, the migrants worked everyday of the week with no days off unless they requested a day without pay. The only time the participants were available for interviews was at the end of the workday after dinner had been taken, usually between the hours of 8.00 - 11.00 p.m. However, even after returning home at the end of a day's work, there were children to attend to, water to fetch, food to be cooked, clothes washed and other domestic tasks, much of which was done by the women. This made it very difficult to have enough time to carry out interviews.

As regards data collection from key informants, only governmental, non-governmental and private Thai health care providers were involved. It was not possible to interview traditional healers, midwives, 'injection doctors,' or by self-trained health providers, referred to by participants as smart people. Largely this was due to the fact that these types of health providers were transient and did not want to be identified by outsiders.

Finally, language was an on-going challenge. Language issues arose:

- among the three teams of principle investigators and research assistants;
- between the research assistants and largely illiterate participants;
- in locating competent Shan/Burmese-English translators for detailed interview transcriptions;
- providing input into the analysis and feedback of the research process due to the limited conceptual vocabulary and knowledge base of the participants; and
- during training workshops that were conducted in four languages (Thai, English, Burmese and Shan)

Fortunately, all those carrying out the research spoke several languages. This provided for a variety of translations and back translations to check for accuracy and comprehension. However, it was inevitable that with each translation there was a risk of miscommunication and lost information.

1.6 Ethical Considerations

In addition to the standard ethical considerations implicated by conducting research with human subjects (such as obtaining informed consent), several related issues had to be considered in carrying out research on sexual behavior among migrant workers. In addition, research on illegal migrants heightened the importance of confidentiality of information, physical safety of researchers and informants, need for specialized training of interviewers, and responsibility of the researchers to provide informational materials and referral services. The last point necessitated collaboration with local Thai organizations and activists.

Oral, rather than written, consent was obtained from every respondent because of the illegal status of most of the participants. The tape recording of in-depth interviews and focus group discussions was also conducted with the oral permission of the participants. While developing the population sample, potential participants were fully informed about the nature of the study and were given an opportunity to ask questions or express concerns. The interviewers also explained the means by which confidentiality was to be assured. In addition, researchers emphasized that the decision of whether to participate in the study or to answer or not answer any particular question(s) was completely voluntary.

Maintaining data records using only identification numbers minimized risks to subjects' confidentiality. Only research team members, who are expected to maintain the highest standards of ethical research practice, had access to the data. The interview schedules, tapes of interviews, and survey data are stored at the Institute of Population and Social Research, Mahidol University in Nakhonprathom, Thailand.

Participants were not subjected to any physical risks. They were asked about personal matters that may have evoked emotional responses, particularly in recounting events that included political and economic violence and sexual coercion; however, the psychological risks to subjects were minimal and were balanced by the opportunity to discuss such experiences with a sympathetic listener. In addition, interviews were usually conducted in a private and safe space in the community that had been identified with the help of key informants or the participants themselves.

The direct benefits to individual participants included the opportunity to inquire about HIV infection, family planning, and other sexual health issues. Researchers also provided participants with referrals to local non-government organizations that offered health services specifically to migrants from Burma residing in Thailand.

1.7 Looking Forward

The following chapters of this report will present the context for and actual findings of this study. An overview of reproductive health and migration issues in Burma and Thailand will be highlighted in Chapters Two and Three respectively. Chapter Four will provide a profile of the migrants from Burma in Thailand who participated in this study. Chapter Five will present the overriding issues of violence and abuse that surfaced throughout all aspects of this study. Chapter Six will discuss the general health problems among migrants and their access to health care in Thailand. Chapter Seven will portray the findings surrounding sexuality and reproductive health among this migrant population exploring the changes and realities they face. Finally, Chapter Eight will provide a summary and offer points for consideration to respond to the concerns and issues raised in this study and during the dissemination process of the findings.

Given the limited reproductive health care services available to the general population within Burma, migrants are even less likely to have access to such resources and services. In Thailand, the present approach to framing and delivering reproductive health services also further isolates migrants who are often undocumented, hold lower economic and social status, young, and often linguistically and culturally different from others in their new communities. For many migrants, particularly female, the issues surrounding violence and fear also directly impact their reproductive health and ability to access services.

Chapter 2
Migration and Reproductive Health in Burma

Official policies instituted by the government of Burma are critical to understanding the reproductive health and migration flows of the country's people. Although there are a wide range of factors influencing reproductive health and migration, national policies and governance have clearly been a strong influence. This chapter discusses official policies that have directly impacted migration flows and the reproductive health status of the people of Burma. The implications of these policies for those who have migrated to Thailand are discussed at the conclusion of this chapter, providing a background for the study's findings.

2.1. Migration

Migration within Burma, as well as into neighboring countries, is an extremely sensitive issue. This has resulted in limited access to migrant populations and placed constraints on information, further restricting knowledge and recognition of migrant populations and their needs. Therefore, documentation on the wide range of factors that contribute to migration has been limited largely to organizations outside of Burma. This section will address the official policies of the government of Burma that have had a direct impact on migration, including political, economic, and environmental policies.

2.1.1 Political

Burma has had a one-party political system for over thirty years that has repressed all opposition, resulting in large-scale migration. The ethnic minority populations in particular have been greatly affected by this political system, which has not been open to cultural diversity, but rather has imposed a national language, culture, and religion. During the past thirty years,

military conflict with ethnic opposition groups has been rampant, especially in the border areas, resulting in large-scale migration. In addition, anyone who has challenged the one-party system has either been killed, arrested, forcibly relocated, has chosen to hide underground, joined opposition groups (especially in the border areas) or has gone abroad. Those who have left Burma have included many intellectuals, students, monks, health professionals and others throughout the country who were forced to migrate for fear of political persecution. Consequently, refugees and displaced persons are to be found in all countries neighboring Burma (Lintner, 1994; Smith, 1991a).

The government of Burma has implemented 'resettlement programs' since the 1950s, with an escalation of these initiatives since 1988. These resettlement programs have been imposed either for "counter-insurgency" operations or "urban development". In some areas with large minority populations, up to twenty percent of the population has been forced to move (Venkateswaran, 1996). In one particular resettlement scheme, 250,000 people were relocated from Yangon[11] to two new satellite towns outside of the city. Both types of resettlement programs typically give people between seven to tens days notice, with little or no compensation for their homes or land. The new locations are known to be unprepared to receive massive influxes of people and are extremely limited in provisional infrastructure and social services, such as health care and education.

Conscripted labor has been a national policy since the State Law and Order Restoration Council (SLORC) came to power and has been largely imposed on those residing in rural areas. Forced labor has been used on a variety of government projects, such as the construction of roads, airfields, railways, hydroelectric plants, and army barracks. In addition to being imposed, such labor is unpaid and those conscripted suffer severe work conditions, especially in minority areas. These policies have been extended to include forced conscription of porters for military troops, who often encounter severe injuries and, sometimes, even death (United Nations Special Rapporteur on Myanmar, 1993).

Finally, it is critical to point out that the government of Burma has strict citizenship laws that make it extremely difficult for many people in Burma to qualify. The Citizenship Law in Myanmar defines three classes of citizens, which specifically discriminate against racial and ethnic minorities. The law requires that a person produce evidence that his or her ancestors were settled in some part of the national territory prior to 1824, when the British colonized Burma (Venkateswaran, 1996). Consequently, when many residents of Burma move they find it difficult or impossible to establish themselves and/or return home.

2.1.2 Economic

The United Nations designated Burma as a Least Developed Country in 1987. The government of Burma's policy, known as the Burmese Way to Socialism, promoted isolation

11 Yangon, the capital of Myanmar, was previously named Rangoon and was changed along with the name of the country in 1990.

that sealed the country off from the outside world for nearly thirty years. The economic impact of this policy is most clearly evidenced by the changes in the rates of rice exports (a critical product for a predominantly agrarian society). In 1962, when SLORC first came to power, rice exports were two million tons per year. In 1988, despite a doubling in production, there were virtually no exports (Smith, 1991a). Another example of the government's isolation is its control of the country's exchange rate, which currently stands at 6.7 kyats to one US dollar, while the black market value is over 200 kyats to the dollar. As a result, corruption and black market activities in Burma have become a primary means of survival throughout the country.

The government of Burma introduced its "Open Door Trade" policy in 1988 to help the country move from a "socialist centrally-planned" economy towards a "free market" one. This policy included an opening of border crossings, particularly into Thailand and China, and promoted foreign investment in the country. This further encouraged migration as economies flourished in the border areas. However, trade with foreign investors largely revolved around the purchase of natural resources, with limited opportunities for economic investments that would provide for a higher standard of living among the people of Burma (Lintner, 1994). At the same time, opium production and exports have increased 8,000 percent since 1960 to approximately 2,575 tons of raw opium that were produced during the 1992-1993 harvest season (Lintner, 1994).

While there are increased trade opportunities with the newly opened border crossings, the government of Burma has maintained restrictive laws on movement that are often enforced solely at the discretion of local officials. Myanmar's Immigration Act of 1947 (section 4.2. and 13.1.) states:

No citizen of the Union of Myanmar shall enter the Union of Myanmar without a valid Union of Myanmar Passport or a certificate of the Union of Myanmar. ... [Those not abiding] [s]hall be punished with six months to five years imprisonment or with a fine of a minimum of Ks 1500 or with both.

This law leaves traders and migrants increasingly vulnerable due to their lack of documentation and efforts to avoid government officials. The law seems to have had no affect on limiting migration, but rather has increased the vulnerability of migrants to arrest and violence as they seek covert routes to cross borders.

2.1.3 Environmental

With the new "Open Door Trade" policy, the government of Burma has sold concessions for timber, rubies, oil, and fishing. All these concessions have resulted in mass migration and relocation to either work for the new businesses or to make room for them. For example, estimates of as many of one million Burmese have gone to the northern ruby mines for jobs. While others, such as local fishermen, have been forced to migrate. For instance, in 1993 the government sold concessions to over 280 modern trawlers from eight Thai companies, who were allowed to renew their fishing permits, thereby depriving Burmese of their livelihood (Smith, 1994). There are numerous examples of how these new concessions for Burma's natural resources are forcing local residents to migrate.

The government of Burma's gas and hydroelectric projects have begun, and will continue, to displace hundreds of thousands, if not millions, of people (Smith, 1994). In addition, such projects are known to cause damage to fish, wildlife, and the ecosystem. This will lead to increased vulnerability of many individuals and their likelihood to also migrate.

Finally, logging in Burma has resulted in a deforestation rate of 800,000 to 1,000,0000 hectares each year, one of the fifth highest rates in the world (Rainforest Action Network, 1993). This is the result of the concessions sold by the government of Burma and minority opposition groups along the border areas. As a result, many families have been forced to move, as the logging ventures have directly destroyed their homes and/or livelihoods.

2.2. Reproductive Health Laws and Policies in Burma

Burma has some of the highest rates of maternal morbidity and mortality in the world. The World Health Organization and UNICEF estimate that the maternal mortality rate in Burma is as high as 500 to 580 per 100,000 live births (World Health Organization, 1997). The government of Burma estimates the maternal mortality rate in the country at 140 per 100,000 live births, but even this lower figure means that Burma has the third highest maternal mortality rate in East Asia and the Pacific Region (Smith, 1996).

With abortion illegal in the country and contraceptives only legal since 1991, an estimated one-third to one-half of maternal deaths has been the direct result of unsafe abortions (Ministry of Health & United Nations Population Fund [UNFPA], 1999). Despite incomplete data, unsafe abortions are widely believed to be a leading cause of morbidity and mortality among women in Burma (Ministry of Health & UNFPA, 1999). In various studies throughout Burma, abortions accounted for at least one third of all maternal deaths (Ba Thike, 1997; UNICEF, 1991; Khin Than Tin & Khin Saw Hla, 1990). In one study carried out in Yangon's Central Women's Hospital in 1994 (Ba Thike, 1997), septic induced abortions accounted for 60 percent of all maternal deaths. Women with no formal education and low income were found to be more likely to seek unsafe abortions (Ba Thike, 1997). All of these studies acknowledge underreporting of induced abortions, given that abortion is illegal in Burma. One study, which attempted to document under-reporting, found that only 30 percent of women known to have had induced abortions would admit to it upon follow-up visits (Figa-Talamanca, 1986).[12]

Given these high rates of maternal mortality, safe motherhood is a critical issue throughout the country. It is estimated that 70 to 80 percent of the births are delivered at

12 This data is based on studies and government statistics in townships predominantly in seven divisions of central Burma and includes very little information (if any) on the seven minority States, which are comprised largely of ethnic minority populations. The little data available from government health centers in minority States such as Kachin, Kayah, Chin, and Mon shows that admissions of women for child-birth delivery are equal ro those seeking treatment for abortion complications (Ba Thike, 1997).

home (World Health Organization, 1997), with postpartum haemorrhage representing a relatively common complication (Ministry of Health & UNFPA, 1999). In addition, over sixty percent of the pregnant women in Burma are estimated to suffer from anemia (UNICEF, 1995). Basic health services are provided to 209 of the 320 townships, most of which are located in central Burma where 70 percent of the population lives. However, basic health services only reach about 48 percent of the population in the 209 townships, according to the Government of Myanmar and the United Nations Population Fund (1994). For those populations not receiving basic health services (predominantly the outlying ethnic minority areas), infant mortality rates are nearly four times higher (UNICEF, 1995).

The government of Burma has developed a multi-layer health care system with Township Health Stations, Rural Health Centers, and Sub-centers. Though the system in theory provides access for people at the village level, there are many obstacles that interfere with the provision of care. These include "chronic shortages of drugs, insufficient equipment and inadequate numbers of staff in many areas" (World Health Organization, 1997).

However, the constraints lie not only in the limited availability of general reproductive health commodities, services, and information but also in their quality and delivery. As noted above, just over half of the country receives general reproductive health services and an estimated 70 percent of the people in Burma are unable to obtain safe and effective contraceptives. This is not entirely due to the lack of resources, but rather reflects official laws and policies that limit the availability of and access to contraceptives. For example, international organizations have had to withdraw or place on hold their assistance to the government of Burma because of the government's "inappropriate health practices and distribution problems" (Smith, 1996). The International Committee for the Red Cross raised their concerns about the government's health and humanitarian practices, and ultimately withdrew from Burma in 1995, after failing to receive a response from the government. In addition, the United Nations Development Programme (UNDP) put a hold on their aid to Burma in 1992 in order to review whether such aid was actually reaching the people it was intended for (Smith, 1996).

Following its independence from England in 1948 and continuing until 1991, the government of Burma promoted a pro-natalist policy (Ministry of Home Affairs National Population Committee, 1992) that encouraged childbearing. However, a 1983 study conducted in the capital city found that approximately 20 percent of married couples were using or had used some type of birth control method (Kyaw Tint, 1983). In another study carried out in 1989 (Hla Pe, et al., 1992) in two rural areas, nearly 35 percent of the couples interviewed had practiced some form of birth control at least once in their married life. What was more disturbing about the findings of the latter report was that the occurrence of abortions was higher among couples who practiced birth control (36.63 percent), than those who did not (20.42 percent). The report found a statistical association between birth control practices and abortions, which indicated a high rate of contraceptive failure (Hla Pe, et al., 1992). This was later confirmed in a study by Ba Thike (1997). Such data, together with the high maternal mortality rate from unsafe abortions, evidences the critical unmet need for contraceptives, as documented by the World Health Organization (1997).

In 1991, the government of Burma recognized that making contraceptives available was an important way to prevent unwanted pregnancies, and to reduce the high rates of abortion and maternal and infant mortality rates. The government,of Burma however, refers to its contraceptive programs as "birth spacing," in its efforts to uphold a pro-natalist position. Moreover, the government did not legalize the sale and use of condoms until 1993. This has not only had an impact on contraceptive choices, but has also impacted on the protection against sexually transmitted diseases (STDs), especially HIV/AIDS (Beyrer, 1998).

The first government-supported "birth spacing" project was introduced by the Ministry of Health in 1991 in the Zigone Township in Bago. Funded by Family Planning International Assistance (FPIA - an international non-governmental organization) the project had expanded by 1994 to include four sites, including those in Mandalay and Magwe. In 1992, the United Nations Population Fund helped to expand this model project to twenty additional townships. In 1994, UNDP funded "birth spacing" programs in six other townships (Thein Thein Htay, 1996). Thus, by 1994, thirty townships were receiving birth control services. These services extended to 79 of the 320 townships,[13] following an agreement between the Myanmar Government and United Nations Population Fund for a US$3.5 million "birth spacing" project over a three year period (Government of Myanmar and UNFPA, 1994). As of 1999, 117 of the 320 townships were receiving "birth spacing" services (Ministry of Health & UNFPA, 1999). In addition, UNHCR and Mother and Maternal Child Welfare Association (MMCWA) have funded "birth spacing" programs[14] on an emergency basis to those repatriated from Bangladesh (Smith, 1996).

In addition to the limited supply of drugs, equipment, and staff implementing "birth spacing" programs, clients are also faced with health service providers who are inadequately trained. For example, one study found that although 400 to 500 intra-uterine devices (IUDs) were received by each township that had "birth spacing" programs, only 38 percent of the government health centers reported having the necessary instruments for insertion. Another study, among "lady health visitors and midwives", found that 78 percent of these health care providers were trained to insert IUDs, but most lacked the necessary instruments to do so (McConville, 1995).

Given the limitations of government health services, the largest provider of health care, including that related to birth control, is the private sector (Ministry of Health and UNFPA, 1999). Several studies from central Burma where "birth spacing" programs have been established report that up to sixty percent of the couples using contraceptives purchased them from the market place, street vendors, friends or relatives (McConville, 1995; Hla Pe, et al., 1992; Than Than Tin, San Shwe, & Thein Thein Htay, 1994). This is true not only for contraceptives, but also for drugs and goods associated with a variety of other health care needs. The private health sector has also played an increasingly active role in meeting the broad range of health care needs in Burma (Smith, 1996).

13 This would provide coverage for approximately 22 percent of the country.

14 Under the technical assistance of Myanmar's Department of Health.

Yet, many of the contraceptive products available in the markets and the private sector are not monitored for their quality, safety, or efficacy. In fact, some contraceptive drugs do not source the expiration date, country of origin, or instructions for use. In addition, many of the private sector providers of contraceptives are not health care providers, but retailers who are not qualified and cannot advise on the suitability, or safety of the product. Many traders purchase drugs and contraceptives from neighboring countries and return to sell them in the markets throughout Burma. These traders or retailers have little or no knowledge of how to use the product, or of the side effects, or treatment of such side effects. Even IUDs are typically bought in the market and taken to a general practitioner for insertion (McConville, 1995). According to Ba Thike (1997), the prevalence of contraceptives in Burma is estimated to be 34 percent in urban areas and ten percent in rural areas, with high mortality arising from clandestine abortions, as a result of both the lack of availability and high contraceptive failure rates.

There remains a critical unmet need for safe and effective contraceptives to be provided by trained service providers in Burma (World Health Organization, 1997). A study conducted by the Myanmar Ministry of Home Affairs (1992) found that 46.4 percent of the women surveyed did not want any more children and 24 percent wanted more at later date. If all these women had become contraceptive users, the prevalence rate would have increased from 16.8 percent to over 70 percent (UNFPA, 1996). These realities are most dramatically seen in the high maternal mortality rates, which range from 100-500 per 100,000 live births. Two studies found abortions to be the leading cause of maternal death in Burma (Krasu, 1992; UNICEF, 1991).

The government of Burma's "birth spacing" policy has begun to address the high demand for contraceptives throughout the country, although continued expansion will be necessary. Considering that only 117 out of 320 townships (Ministry of Health & UNFPA, 1999) have been targeted for "birth spacing" programs, it will be a long time until such services reach the wider population.

There are serious issues that must be addressed as the government expands its "birth spacing" and reproductive health services. Understanding how reproductive health issues and interventions are framed and the factors that interfere with an equal and non-discriminatory approach to them is critical. Below the issues of gender, marital status, ethnicity, socio-economic status, and access to information in Burma are discussed.

2.2.1 Gender

Women in Burma have limited opportunities to raise their concerns and provide input into policy decisions. Although women make up 40 percent of the labor force and attend university in larger numbers than men, few women have ever been allowed to rise to top government positions. In addition, there is no official agency or ministry in Burma to advance or protect the status of women (Smith, 1996). Yet, women play an important role in the framing of reproductive health policies. This is especially true considering that contraceptives in Burma have primarily focused on women. Since condoms remained illegal until 1993, they still carry a great deal of stigma throughout the country (Smith, 1996). In addition, male

sterilization (vasectomies) remains illegal and therefore is not offered by government health services (World Health Organization, 1997).[15]

In addition to the limited role women play in policy making, the impact of violence against women has been largely unaddressed in Burma and directly impacts on girls and women's health and their ability to seek intervention and care. Particularly disturbing are the numerous accounts of rape throughout the country documented by migrants abroad (Asia Watch, 1992; ALTSEAN, 1997; Amnesty International, 1998; Earthrights International, 1998). In addition, conservative figures estimate that each year 10,000 girls and women from Burma are trafficked into the sex industry in neighboring countries, particularly Thailand and China (Asia Watch, 1993). Only recently has the government of Burma begun to discuss these issues and others surrounding violence against women. To date the extent and impact of these ongoing realities have remained largely unacknowledged within Burma.

2.2.2 Marital Status

Birth control policies, programs, and research in Burma have focused exclusively on married women of reproductive age. The government's pro-natalist stance and the fact that contraceptives have only been legalized since 1993 evidences the government's position that all couples should have children. The fact that "birth spacing" programs are only provided for "married women of reproductive age" is framed in a way that excludes those who are not married, or do not want children immediately, or at all.

The findings from two studies conducted prior to the introduction of the government's "birth spacing" programs provide some insight into the demand, and potential discrimination, associated with birth control programs that focus on women who already have children. In one study conducted in 1989 with two rural populations (Hla Pe, et al., 1992), women who married as teenagers (under 20 years old) used "birth spacing" practices the most (36.4 percent), followed by married women between the ages of 20-24 (31.3 percent). In addition, 24.4 percent of the couples interviewed with no children practiced "birth spacing". Similar findings were also noted in the Thanatpin Study (Bo Kywe & Maung Maung Lin, 1993), where 44 percent of married women of reproductive age without children were currently using contraceptives compared to 14 percent who had more than five children. However, contrary to these findings, "birth spacing" programs in Burma focus on providing contraceptives to women already with children and assumes that contraceptive use is a concern only for older women and couples who already have several children.

There has been little effort to address the contraceptive needs or provide related services for unmarried women or adolescents, despite the obvious need that has been documented (Ministry of Health & UNFPA, 1999). The few studies that have focused on pregnancies and deliveries among adolescents in Yangon show an increased health risk to both the young mother

15 However, vasectomies are unofficially provided through private clinics and are reportedly 'popular' (McConville, 1995; Hla Pe, et al., 1992). There has been no active campaign in Burma to promote condom use nor has an explanation been given for why vasectomies remain illegal. The lack of access to contraceptive methods for men limits their options, and also places additional responsibility, and often burden, on women as a result.

and her newborn (Ba Thike, et al., 1993; Aye Aye Thein, et al., 1995). In one study, the perinatal mortality rate (46 to 67 per 1,000 births) among young women was twice that of women in older age groups (Aye Aye Thein, et al., 1995). Even more troubling is the increasing numbers of unsafe (illegal) abortions among adolescents (Ba Thike, et al., 1992; Ba Thike, et al., 1993). Both studies noted that because of social unacceptability, unmarried pregnant women face greater risks of serious abortion complications, both because of delays in finding someone to perform the abortion and in seeking treatment for complications.

The World Health Organization (1997) has also noted that insufficient data is available on the reproductive health of adolescents in general. This is an area in much need of attention, given that preliminary indications show that youth may suffer from a high incidence of STDs and other reproductive health vulnerabilities.

2.2.3 Ethnicity

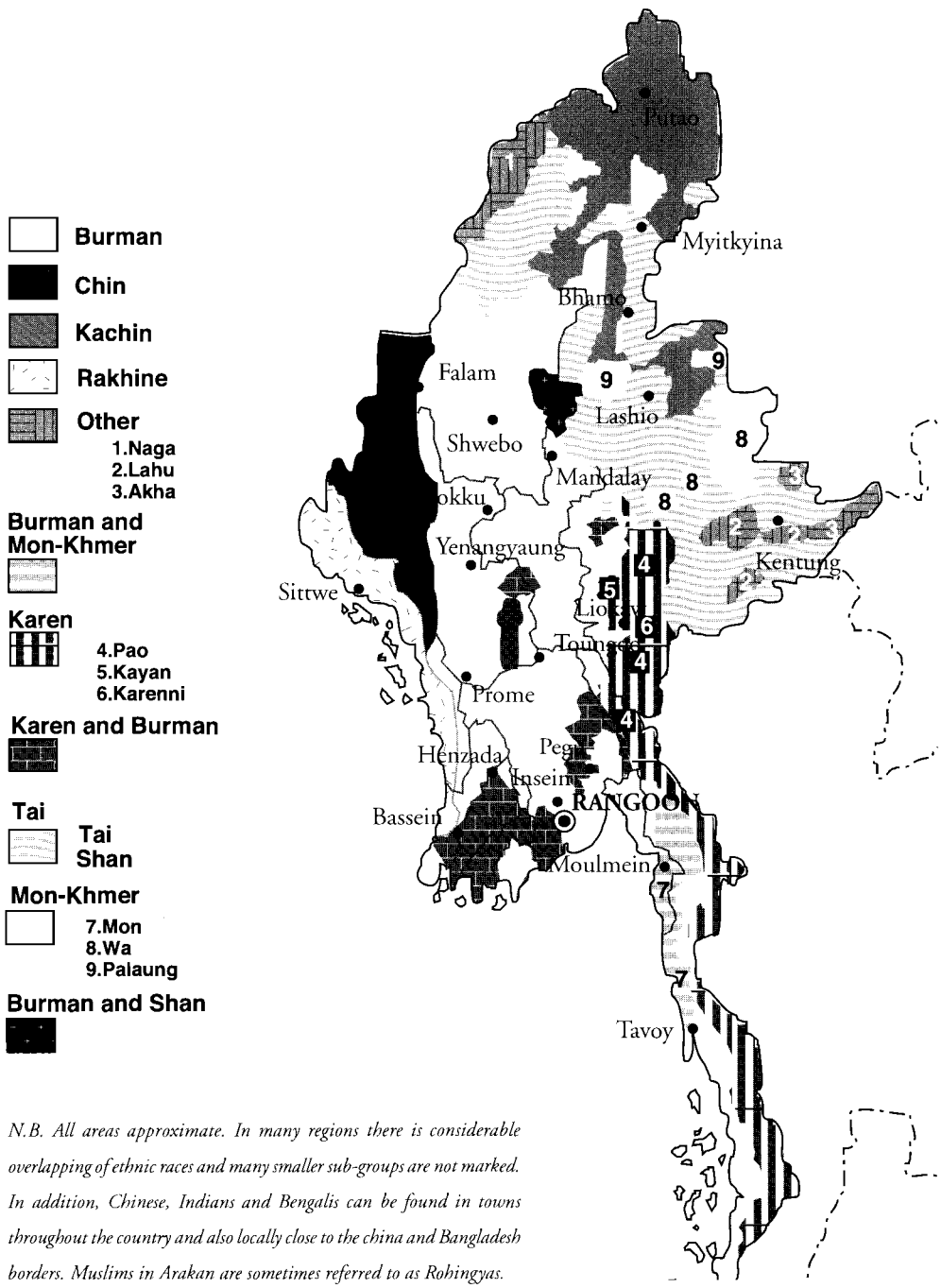
The ethnic minorities constitute an estimated one third of the population of Burma and include over twenty different groups (see Figure 2). Many of the minority populations have been in conflict with the current government and its policy of promoting a Burman society with one culture, religion, and language. Their lack of autonomy has resulted in minority opposition groups taking up arms against the military regime for over thirty years (Smith, 1991a; Lintner, 1994). Consequently, minority areas have been largely cut off from the central government, as well as from outside observers and international aid. Although fragile cease-fire agreements have been made with many of the minority opposition groups, there has been little change in the situation that has continued to include exchanges of artillery, displacement, and ongoing abuses.

As a result, the ethnic minority areas of Burma have had limited public health care services, if any at all. There remains a serious lack of doctors willing to work with these communities, which are often located in remote areas. Consequently, those who are forced by the government to administer services in minority areas, often do not turn up for work, or simply apply for a transfer immediately upon arrival. For example, in 1995, the government of Burma reported that 500 government health posts were vacant, and in some minority areas more than a third of the positions for doctors remained unfilled (Smith, 1996). The townships targeted for "birth spacing" programs have not yet reached vast areas where ethnic minority populations reside.

2.2.4 Socio-Economic

Health care in Burma, both public and private, is provided according to a client's ability to pay for services. If a client is financially unable to do so, there are no, or extremely limited, services available (Smith, 1996). Payments are not only necessary for basic drugs and services, but also for many smaller items such as needles, dressings, and even sheets in the hospital. In addition, drugs and supplies are often unavailable and patients must purchase them from the markets. This is largely due to chronic under-funding, underpaid staff, and large-scale corruption. Furthermore, Ba Thike (1997) notes that the cost of contraceptives and reproductive health services, although low, remains a critical barrier for poor women. As a result, women often rely on cheaper contraceptives available in the markets that are of questionable quality and safety.

Figure 2 :
Ethnic Groups in Burma



N.B. All areas approximate. In many regions there is considerable overlapping of ethnic races and many smaller sub-groups are not marked. In addition, Chinese, Indians and Bengalis can be found in towns throughout the country and also locally close to the china and Bangladesh borders. Muslims in Arakan are sometimes referred to as Rohingyas.

Source: Adapted from Martin Smith, Burma: Insurgency and the Politics of Ethnicity, Zed Books, 1991

The military in Burma plays a strong role in the political and public services systems, which often results in alienation of citizens not connected to or in support of the military's position. The government of Burma frequently imposes laws and policies without clear guidelines and local military officers often make decisions related to public services programs (Smith, 1991b). Consequently, many of the laws and policies are arbitrarily implemented at the local level, without any means for recourse to confront discrimination, or challenge the local authorities' decisions and actions.

An example of how this directly impacts access to contraceptives is the government's policies for sterilization. In order for a woman to receive a tubal ligation at a public hospital, she and her partner must apply to the government for permission. This requires the couple to complete an application form for submission to the 'Sterilization Board' at the district (or State) level, requesting the procedure for health reasons. However, Ba Thike, et al. have noted (1993) that:

> *The term 'health' is considered in a broad sense and each individual case is evaluated on its own grounds. There are no specific set of requirements that applicants have to fulfil regarding age and parity but most obstetricians have arbitrarily set the minimum age as 30 years and already at least three children.*

In other areas, no explanation has been given to those not approved. For example in 1990, out of 6,694 applications to the Yangon Sterilization Board, nearly 1,000 requests were denied. This process can take several months and those rejected were not informed of the reasons why (Ba Thike, et al., 1993). Finally, those who are accepted must be able to pay between 1,500 and 10,000 kyats for this public service, which is out of reach for most poor people (World Health Organization, 1997).

2.2.5 Access to Information

The right to access and publish a wide range of information also directly impacts contraceptive policies, services, and choices (Freedman, 1995). The government of Burma has countless laws and policies severely restricting basic rights, such as freedom of movement, information, and association (Venkateswaran, 1996). In addition, the government's strict censorship laws have placed serious constraints on the freedom of information and expression among policy makers, health providers, and potential and actual contraceptive users.

The government of Burma's broad and comprehensive censorship laws, make it an offence to instigate, protest, say, write, or circulate information on anything that could:

> *Disrupt and deteriorate the stability of the state, communal peace and tranquility, and the prevalence of law and order ... affect or destroy the national consolidation ... affect, destroy and belittle the tasks being implemented at the National Convention ... and cause misunderstanding among the people (Venkateswaran, 1996).*

This law and other similar martial decrees have been used to arrest and imprison numerous health professionals (Smith, 1996; Chelala, 1998). Dr. Khin Zaw Win is one example of a qualified dentist and former employee of UNICEF who went abroad to study, attending conferences, and continuing his contacts with international health officials. He was arrested upon his return to Burma and was sentenced to 15 years imprisonment, without the right to a defense, for "spreading false news" and other offenses (Chelala, 1998).

The censorship laws in Burma seriously limit the opportunities to obtain information, conduct research, publish findings, and undertake training and dissemination of education materials. Although there is a growing awareness of reproductive ill health, these barriers seriously restrict public discussion and information dissemination. As a result, the understanding of reproductive health concepts and implications for health services have yet to be developed (UNFPA, 1996), and are restricted from meeting the demands for contraceptives. Given the limited availability of information, research, training and education materials for health care providers, women are making choices based largely on word of mouth, availability, and cost (Thein Thein Htay, 1996). This raises concerns about informed consent of clients in choosing their contraceptive methods, dealing with side effects, and requesting termination of or changes to contraceptive use.

The need to develop and implement a more effective information, education, and communication campaigns was recognized by Dr. Thein Thein Htay (1996) as critical to the success of the "birth spacing" programs and other reproductive health services. With access to information, education, and communication on a wide range of contraceptive methods, concerns, and discussions, government officials, health providers, private sector contraceptive suppliers and the people of Burma would be able to make better decisions and responses to their reproductive health needs. Although the government recently announced it was developing a manual on reproductive health, it is not likely to provide policy makers, health providers, or clients a broad perspective and discourse on contraceptives and broader reproductive health issues. Any such manual, by its nature, would only focus on the government's objectives, thereby providing only one point of view on a diverse field of knowledge and perspectives.

In addition to censorship are the problems of literacy, and an imposed national language that is not used by the many ethnic minority populations. The illiteracy rate among ethnic minority women has been reported as high as 86 percent in some areas (Portor, 1995). The illiteracy rate in Burma is uniformly higher among women and particularly high for both male and female in the minority areas (Smith, 1996). This is both the result of few educational opportunities and government policies, which insist that public programs for education, health care, and other services and information be implemented in the Burmese language (Smith, 1991a). It is rare therefore to find educational opportunities and information in ethnic languages, further limiting access to information and education for large sections of the population. This has had a direct impact on the government's "birth spacing" programs and other reproductive health services. For example, when the contraceptive Depo-Progestrone

was made available in the Arakan State,[16] rumors of forced sterilization were spread and strong protests against it were made. This was largely due to the lack of any information about this type of contraceptive, as well as procedures and monitoring to ensure informed consent among its users. This gap in information and distrust, particularly among minority populations, highlights the consequences of limited access to health information, public explanation, and debate (Smith, 1996) in a language and media that is understood and accessible by all citizens.

Finally, it is has been reported that health care providers often choose the contraceptive methods for their patients. One study, which was conducted among 140 health care providers and 27 drug store owners in four townships in Central Burma, found that while 52.1 percent of the clientele chose its own method of contraception, 44.3 percent of the health service providers choose the contraceptive method for their patients (Thein Thein Htay et al., 1996)

In another study conducted in the Taikkyi Township, ten percent of the health care providers "do not consider consumer's choice because of their [the consumer's] ignorance of appropriate methods" (Myint Myint Soe, et al., 1995). Even where government "birth spacing" programs are available, target contraceptive goals have been established (Government of Myanmar & UNFPA, 1994), which arbitrarily decide on behalf of a client the contraceptive method to be used. This is another means of denying women their right to make informed choices about their preferences of contraceptive methods.

2.3. Implications for the Reproductive Health of Migrants from Burma

Given the limited reproductive health care services available among the general population within Burma, migrants are even less likely to have access to such resources and services. Given the sensitivities in acknowledging migrant populations and the abusive realities they often encounter (both in Burma and Thailand), migrants tend to be hidden from public awareness and isolated by their own fears. In addition to the situation described in Burma, migrants in Thailand are either kept in closed camps with strictly controlled access, or they reside and work without documentation, always in fear of arrest. As a result, contact with these populations is extremely limited and sensitive.

For those living in camps, all contacts require the approval of the authorities and any problems can result in additional restrictions or denial of access. Undocumented migrants from Burma who enter Thailand are well aware of the risk of drawing attention to themselves since any such attention may lead to their arrest, detention, and/or deportation. This makes it difficult to contact these individuals, and also greatly restricts the migrants' ability to obtain reproductive health commodities and services.

16 The Arakan State is the one ethnic minority area where "birth spacing" services are provided, in collaboration with international organizations, to refugees returning from Bangladesh.

In Thailand, the government's approach to framing and delivering reproductive health services further isolates migrants, who are often undocumented, hold lower economic and social status, are young, and often linguistically and culturally different from others in their new communities. For many migrants, particularly female, the issues surrounding violence and fear also directly impact their reproductive health and ability to access services.

2.4. Reproductive Health Concerns among Migrants within and from Burma

As previously noted, there is an extremely limited amount of information available on the reproductive health realities of migrant populations within and from Burma. The information that is available largely focuses on the HIV/AIDS epidemic. The following section describes the vulnerabilities of migrants to HIV/AIDS, as one indicator of some of the risks faced by migrant populations from Burma. The impact of high rates of gender violence on the reproductive health of migrants will also be discussed.

Burma is located between Thailand and India, where the estimated rates of HIV infection in 1993 were 400,000 and 1.8 million respectively. Given the reality of migration and the opening of trade and transport between Burma and its neighbors, it is not surprising that Burma is already facing alarming rates of HIV/AIDS infection (Portor, 1995). In neighboring countries, the most alarming rates of HIV/AIDS infection are found along their borders with Burma. For example, some of the highest rates of infection in Thailand are found along the Thai-Burmese border (PATH, 1992). The highest prevalence of HIV infection in China is in Yunnan province, which borders Burma's Kachin and Shan States (as well as Laos). The Chinese Ministry of Health reported in 1995 that 80.4 percent of all HIV infections and 60 percent of all confirmed AIDS cases in China were detected in Yunnan (Zeng Yi, 1995). And, the State of Manipur in India (across from the Chin State in Burma) has the highest percentage of HIV positive cases the country (Department of Health, India 1995).

By the end of 1994, the World Health Organization estimated that the number of HIV-positive individuals in Burma ranged from 400,000 to 500,000. In addition, World Health Organization (WHO) pointed out that those infected were no longer confined to persons engaged in high-risk behavior; the illness had also affected the general population, including women and children (UNICEF, 1995). Among the estimated population infected with HIV in Burma, as of March 1996, 46.7 percent were women attending pre-natal care clinics. Based on this figure, approximately 214,420 pregnant women in Burma are HIV positive (Department of Health, 1996). This estimated figure surpasses every other high-risk category, and is probably the most reliable in understanding the HIV/AIDS epidemic in Burma since it is easier to predict the number of pregnant women than those in other at-risk groups. Moreover, pregnant women's routine testing provides a more valid sampling. If these rates of infection among pregnant women are accurate, other figures have greatly underestimated the HIV infection in Burma since "it is unlikely

that so many 'low risk' women could be infected without a very large [corresponding] number of married men" (Southeast Asia Information Network, 1995).[17]

In the areas in Burma where there has been HIV/AIDS sentinel surveillance data available, the border towns have shown extremely high prevalence rates (in comparison to other areas of the country). Among the HIV sentinel surveillance of high-risk groups, the highest rates of infection were found in Burma's cross-border points with Thailand and in Mandalay in Central Burma (Min Thwe, et al., 1995). Unfortunately, data is only available for several border areas, leaving little known about HIV/AIDS prevalence (and other health realities) in many other migrant and border communities.

Given the profile of migrants within and from Burma, these individuals are likely to find themselves unable to access health services or to relocate into areas where such services are unavailable. This may be due to a variety of reasons that go beyond availability and include factors such as lack of documentation (in that township or country), language skills, limited resources for transportation, or health care costs, and/or trust of health care providers. In addition, discrimination, violence, and fear of reproductive health risks must also be considered.

Girls and women from Burma are at increased risk as a result of high rates of gender-based violence. Violence against women, both within and outside of formal relationships, has a direct and serious impact on reproductive health (National Research Council, 1997). Migrants within and from Burma are extremely vulnerable to exploitation and deprivation of their rights at every stage of their flight, including relocation sites or camps. Many girls and women report having been physically beaten and/or raped in Burma during their migration and/or after their relocation (Earthrights International, 1998; Amnesty International, 1998; Smith, 1996; Asia Watch; 1992). It should also be noted that in Thailand more than 80 percent of the refugees from Burma are women and children. These groups, in addition to exposure to war and physical threats, have been left alone to struggle for the survival of their family in a strange place and an economy distorted by violence (ALTASEAN, 1997).

Trafficking of girls and women from Burma is another form of violence that has direct implications on their reproductive health. Reports of up to 10,000 girls and women from Burma have been trafficked each year into brothels in Thailand (Asia Watch, 1993). There are also reports of girls and women trafficked into sex work in China and India, though no detailed research on this phenomenon is available. In addition, in Rangoon traffickers are reported to have recruited women to migrate to Japan as classical dancers and then forced them into prostitution (Smith, 1996). Many other forms of trafficking remain largely undocumented (Archavanitkul, 1998a and 1998b). To date, the government of Burma's response to trafficking has been limited. The government has attempted to prohibit

17 According to the 1995 report, National AIDS Control Programme in Manipur, by India's Department of Health: "Manipur ranks second highest regarding the total number of HIV cases, next only to the Maharastra State. However, if we calculated the sero-positivity rate per 1 million population, the sero-positivity rate of Manipur is 16 times higher than that of Maharastra State and 24 times than that of Tamilnadu."

cross-border migration of all females, age 16-25, infringing their basic freedoms.[18] Unfortunately, this has resulted in more and more young women moving in unregulated manners and increasing their vulnerability to violence without recourse (Smith, 1996).

This chapter has provided a broad outline of the lives of migrants and the political environment, which affects their decisions to migrate and their reproductive health. Understanding this context is critical since the data collected for this study captures the realities and memories of the migrants at only one point in time. The following chapters provide case examples of the vulnerabilities of migrants and how that impacts their reproductive health.

18 The Myanmar government's immigration policy issued in 1996 prohibits "young women between the ages of 16-25 from crossing the border unless accompanied by a legal guardian." Though this law was issued to protect girls and women, it has had limited effectiveness given Myanmar's extensive borders, and ultimately places the criminality on the young migrants versus the traffickers.

Thai government's policies on undocumented migration from Burma have changed markedly over the last three decades according to changes in Thailand's security policy and the relationship between the two countries. During 1970s and 1980s, most of migrants settled in Thai border provinces. Since the government of Burma's suppression following 1988, hundreds of thousands of people from Burma fled to Thailand and spread throughout whole country. Due to the demands for unskilled labor at that time, the Thai government has used Cabinet resolutions (from 1992-1999) to provide a more flexible immigrant labor policy. Basically, the resolution allowed employers to legally register migrants depending on their type of job and the province in which they reside.

Chapter 3
Thai Government's Policies on Undocumented Migration from Burma

The 1990s saw a massive migration of individuals into Thailand; most of these were refugees, displaced persons, trafficked persons, political asylum seekers, or economic migrants from Burma, Cambodia, and Laos. Several sources estimate that the number of these migrants currently working in Thailand totals approximately one million people, most of whom are from Burma. To understand the current situation of these migrants, it is necessary to examine Thailand's security policy along the Thai-Burmese border, how refugees from Burma are classified, and the policies and measures the Thai government has adopted to control this influx of people. The final sections of this chapter examine the health conditions and public health policies directed toward this migrant population.

3.1 Thailand's Security Policy

The history of Thai-Burmese relations and Thailand's security policy towards migrants from Burma have had a mutual impact on one another. Though, many would say that the Thai government's security policy has had a greater impact on the migration influx than the migrants have had on Thai policy. The Thai state's security policy towards Burma can be divided into the following three periods (Archavanitkul 1998): the cold war era, the waning years of the cold war, and the post cold war period.

3.1.1 The Cold War Era (end of World War II - 1983)

During this period, the Thai government used the ethnic minority armed forces along the border that were fighting the government of Burma as a kind of "buffer state". Official documents of the Thai Supreme Command Headquarters from 1965 state that the security

policy of this period was designed "in order to protect Thailand from an invasion of Communism and/or an invasion from nearby countries, which covertly and/or overtly support Communism." (cited in Sawadirak 1997: 71) This period, then, is characterized by an omni-directional security policy closely aligned with the United States and its efforts to resist the expansion of the Soviet Union's sphere of influence. Such policy brought strong criticism to Thailand since the country was seen as yet another piece on the geopolitical chessboard that the United States could move around at its whim.

3.1.2 The Waning Years of the Cold War Era (1984-1988)

This period marks a time when the Thai government initiated a policy to welcome back members of the Thai Communist Party in its efforts to develop the country. This is the same period when the Socialist Buddhist regime of General Ne Win in Burma began to decline, primarily as a result of its insistence in maintaining a closed society, coupled with disastrous economic policies. During this period, the Thai government became less concerned about security issues with its western neighbor and more interested in securing benefits from a growing border trade. Meanwhile, the Ne Win regime stepped up its policy of suppressing ethnic minority forces, particularly the Mon and Karen armies along the Thai-Burmese border. This armed conflict damaged property and homes in many Thai villages and between 1984 and 1986 the escalating tension drove more than 60,000 people from the Mon and Karen armed forces bases to flee the country and seek refuge in Thailand. An additional 250,000 Burmese affected by the fighting also crossed the border into Thailand. These individuals, representing the first wave of massive refugee influxes into Thailand, scattered throughout the six border provinces of Ranong, Kanchanaburi, Tak, Mae Hong Son, Chiangmai and Chiangrai.

3.1.3 The Post-Cold War Era (1989 to the present)

The post cold-war period marked the rule of Burma's military government known as SLORC - State Law and Order Restoration Council, which succeeded General Ne Win in 1988. In 1997, SLORC changed its name to SPDC or State Peace and Development Council. During this period the government opened the country to foreign investment and embraced capitalism's free market under the slogan "The Open Door Economic Policy," which was first declared in 1989. Following the collapse of the Soviet Union, communism eliminated the perceived threat to the Thai State, and thus maintaining a "buffer state" of minority opposition groups was deemed no longer necessary. The Thai government consequently changed the direction of its security policy and began to actively promote "Constructive Engagement" with its neighbor. In an effort to win SLORC's trust and secure investment opportunities for both public and private sectors, the Thai government began withdrawing from conflicts between SLORC and the ethnic minority armed forces. The relationship between the Royal Thai army and the Burmese army grew closer than in any previous period. Soon an army of Thai investors marched into Burma, such that by 1997 Thailand ranked as the country with the third largest investments in Burma.

By opening the country to investment, the Burmese army was able to acquire significant sums of money to purchase additional weaponry, used mainly to suppress the ethnic minority

forces. During this period, the army began evicting people living in areas where there was strong resistance to the ruling elite and the government escalated its conscription of forced labor for infrastructure projects throughout the country. This caused another massive influx of refugees from Burma into Thailand. At the time, the Thai economy was flourishing and large numbers of unskilled workers were in great demand by the private sector. This confluence of events precipitated refugees to move farther into the interior of Thailand, and later to move throughout the entire country in an effort to secure employment. Consequently, the Thai government tightened its security policy as never before. Documents of the Intelligence Advisor Team, Office of the Prime Minister, dated January 1992 (cited in Sawadirak 1997: 73-75) state:

(1) To build a good relationship with Burma and to try to reduce any conflict and mistrust by showing sincerity in not supporting the resistance forces against the government of Burma and not supporting political asylum seekers. In dealing with refugees, three principles must be considered: the relationship between the two countries, humanitarian principles, and national security. If any members of minority forces flee into Thai territory, they must be disarmed and detained in refugee centers. When the situation is right, these refugees will be repatriated.

(2) To invite the government of Burma to join ASEAN's activities for the political, economic, and social benefits of this region. To expand economic relations, border trade, investment, and academic and cultural cooperation.

(3) To promote continual negotiations concerning the Thai-Burmese border conflict in order to reach an agreement on clear and permanent borders in the future. To cooperate with the government of Burma to solve border disputes, and if a violation of sovereignty occurs, it must be ended quickly at the local level.

(4) To cooperate with the government of Burma in cracking down on narcotics and the chemical trade along the border. To prevent contraband, heavy weapons in particular, from being in the hands of the country's enemies.

(5) To persuade the military leaders in Burma to recognize the national interests deriving from a political system that allows more freedom to the people, and to continue peace talks with the ethnic minority groups.

3.2 Classification of Migrants from Burma

According to a study conducted by the Institute for Population and Social Research entitled "Labor Migration from Burma to Thailand," migrants who illegally enter Thailand are classified into six groups. As of early 1998, it was estimated that the combined total of these six groups was approximately one million people (Archavanitkul 1998). It should be stressed that each classification is not exclusively separate from the others. For example, many of the migrants can be identified as both displaced persons and migrant workers. Also, many of those fleeing Burma are not allowed to stay in refugee camps, while others who escape from these camps are recognized only as migrant workers.

3.2.1 Displaced Persons

In 1962, following Burma's official declaration as a socialist country, armed conflict between the government and minority armed forces broke out. Many ethnic minority groups living along the border, such as the Mon, Karen, Shan, Lahu, and Burmese, were affected by the fighting and ensuing economic hardships. As a result, thousands fled their homeland and settled in Thai border provinces. At first, the Thai government did not record the number of people in this group. Migration continued, however, into the border provinces of Chiangmai, Chiangrai, Tak, Mae Hong Son, Ratchaburi, Kanchanaburi, Prachuap Khiri Khan, Chumphon, and Ranong. Eventually, the Ministry of Interior began to keep official records of those crossing the border by issuing them pink identity cards.[19] These individuals were required to be citizens of Burma who sought refuge in Thailand prior to March 9, 1976. They were referred to as "Displaced Persons of Burmese Nationality." Statistics on the group's birth and death rates were updated occasionally. As of 1998, this group totaled 16,602 persons. The Thai authorities allow these individuals to be permanent residents. They are permitted to work, but only in certain controlled areas (The Registration Administration Bureau, Ministry of Interior, 1999).

3.2.2 Illegal Migrants

In 1994, the Ministry of the Interior began registering and issuing ID cards to those who sought refuge in Thailand after March 9, 1976. These individuals are classified into two groups: "illegal migrants with permanent residence in Thailand" (those holding orange cards) and "migrant workers living with their employers" (those holding purple cards). There are approximately 13,650 persons in the first group and 106,937 persons in the second group (The Registration Administration Bureau, Ministry of Interior, 1999). These individuals have been permitted to work in specific controlled areas since 1992 when a Cabinet resolution was passed allowing for the employment of Burmese labor in ten border provinces, but only on the condition that employers are unable to hire Thai workers.

3.2.3 Refugees from Threats of War

These are the ethnic minorities from Burma who have fled border fighting and have moved to the Thai districts of Tak, Kanchanaburi, and Mae Hong Son. Their numbers have continued to rise since the suppression of the 1988 student-led demonstrations and a subsequent crackdown on minority armed forces near the border in 1994. Thai authorities house these refugees in eleven camps.[20] According to a survey conducted by UNHCR (United Nations High Commission on Refugees) in November 1999, there were a total of 97,700

19 The color cards are a special form of identification issued by the Ministry of Interior to ethnic minority and illegal migrants free of charge in order to monitor the influx of migration. Fourteen separate colored cards are granted to each of the fourteen different groups of minority and illegal migrants in Thailand.

20 The Thai State does not acknowledge refugees from Burma as "refugees," but instead refers to them as "displaced persons from fighting". The shelters housing this group of people are officially referred to as "remporary shelters for displaced persons from fighting". Official documents and Thai aurhorities do not use the term "refugee camp."

refugees[21] housed in these temporary shelters. These refugees are not allowed to work, except for various odd jobs within the camps. In certain provinces they are permitted to work outside the camp, but only on a temporary basis during day light hours. Despite these regulations, a large number of refugees are able to find work in provinces adjacent to their camps.

3.2.4 Students/Intellectuals

This group fled to Thailand as a result of political turmoil in Burma, particularly following the widespread arrests of student leaders and intellectuals in 1988. A number of students were repatriated before the Thai government set up a 'safe area' at the Manee Loy Centre in Ratchaburi province. UNHCR was allowed to register and provide some support to these individuals, who were classified as"Persons of Concern". In order to obtain this status, individuals were first required to prove that they were involved in the 1988 demonstrations. A number of students chose not to stay at the Centre because they did not want to officially acknowledge their participation in political activities, either for fear of future reprisals by Burmese authorities (whether to themselves or their families) or because they wanted to continue their activities in exile. Those who could not provide sufficient evidence of their involvement in the demonstrations were denied UNHCR status and were not allowed to remain at the Centre. Some reported themselves as displaced persons and were placed in various camps along the border. There were also those who did not report themselves to the authorities. These students and intellectuals came to further their political activities and did not originally intend to work in Thailand. However, out of necessity and prolonged political problems a large number of them eventually entered the labor force illegally.

As of 1998, the number of students registered with UNHCR was 2,231. Of this number 1,641 students were sent to a third country. However, when Burmese students seized the Myanmar Embassy in Bangkok on October 1, 1999, the Thai government demanded that those students living outside the Manee Loy Center report themselves immediately to the authorities so that they could be sent to a third country. By December 1999, 2,906 students registered with Thai authorities. Of this number, 1,003 students live at the Centre.

3.2.5 Visitors Who Chose to Remain in Thailand

This group traveled mostly by plane to Thailand, presumably for only a limited stay. However, according to the Office of the Immigration Control, between 1991 and 1996, 329,066 persons from Burma entered Thailand, while only 314,184 exited the country. Those who over-stayed their visa at the end of 1996 totaled 14,882, most of whom were male.

3.2.6 Illegal Migrant Workers

This group deliberately entered Thailand to seek employment. They fled a life of poverty, starvation, and high unemployment in Burma. This is the largest group of all, though

21 There are also four camps on the Burmese side of the border that house a total of 13,278 refugees (BBC 1999).

their exact numbers are unknown since the majority of them work illegally. Various agencies estimate that this group totals approximately 600,000 to 900,000 individuals. The number of those who are registered and have received work permits will be discussed in the next section.

3.3 Policy on Refugees from Burma

Thailand has not ratified the 1951 United Nations Convention Relating to the Status of Refugees and the subsequent 1967 Protocol Relating to the Status of Refugees. The Thai government, therefore, has limited legal obligations under international law regarding the treatment of displaced persons. Furthermore, it does not use the word "refugees" to describe persons who have fled across the border. Instead the government uses a Thai word that can be translated as "temporarily displaced". The "temporarily displaced" refer specifically to those that are either residing in camps or who are waiting to be processed into those camps. There are many thousands, probably hundreds of thousands, of others fleeing human rights abuses who are not treated as "temporarily displaced".

Displaced persons under Thai national law are, in legal terms, equivalent to illegal migrants and subject to deportation. Immigrant Act 2522 B.E. (1979) stipulates that any person entering the country without certified papers is an illegal immigrant. Under Article 17 of the Immigrant Act, the government can exercise its authority "in special cases (when) the Minister by an approval of the Cabinet can permit any alien to enter the Kingdom under any condition or can be exempt in any case from complying with this Act." That is, the government can pass a Cabinet resolution and use it as guidelines for dealing with different cases of displaced persons. The Thai government uses this power to help displaced persons from Burma by providing them shelter in camps along the border, in accordance with humanitarian and Thai law. In principle, there should be strict controls over those entering and exiting the camps. Yet, in practice, the degree of control varies in each border province, depending on the co-operation between the officers in charge, who are mainly officials from the Ministries of Defense and Interior.

When setting up permanent camps, the Thai government permits several international NGOs to assist these displaced persons. The Coordinating Committee for Services to Displaced Persons in Thailand (CCSDPT), a government organization, was established under the supervision of the Ministry of the Interior to also assist these individuals. CCSDPT is comprised of three subcommittees, namely: (i) CCSDT Primary Health and Sanitation, (ii) CCSDT Education, and (iii) CCSDT Food, Relief and Educational Supplies. The key international organizations working in the camps are MSF (Medecins Sans Frontieres-France), together with AMI (Aide Medicale Internationale) and MHD (Malteser-Hilfsdienst Auslandsdienst E.V.), and the Burmese Border Consortium (BBC). This consortium is a network of organizations that include, inter alia, JRS (Jesuit Refugee Service), IRC (International Rescue Committee) and ZOA (Zuid Oost Azie Refugee Care).

During the past five years, the Thai government's policy towards Burmese refugees has changed significantly. One major event was Burma's official membership into ASEAN (The

Association of South East Asian Nations). All of the ASEAN countries maintain a "constructive engagement" policy with Burma, primarily because of their economic interests in the country. Consequently, they were more than eager to support Burma's petition to join ASEAN in 1997. Shortly thereafter, both the Thai and Burmese governments exerted extreme pressure on minority forces in Burma until they were driven to enter negotiations to disarm. Several groups lost their military bases and were effectively disbanded. Currently, only a few Karen forces still pursue armed resistance. During 1997-1998, fighting often crossed the border into Thai territory and included three arson attacks on refugee camps set off by Burmese authorities in the Mae Sot District of Tak Province. The problem of the protection and security of refugees along Thai-Burmese border was increasingly becoming more and more serious.

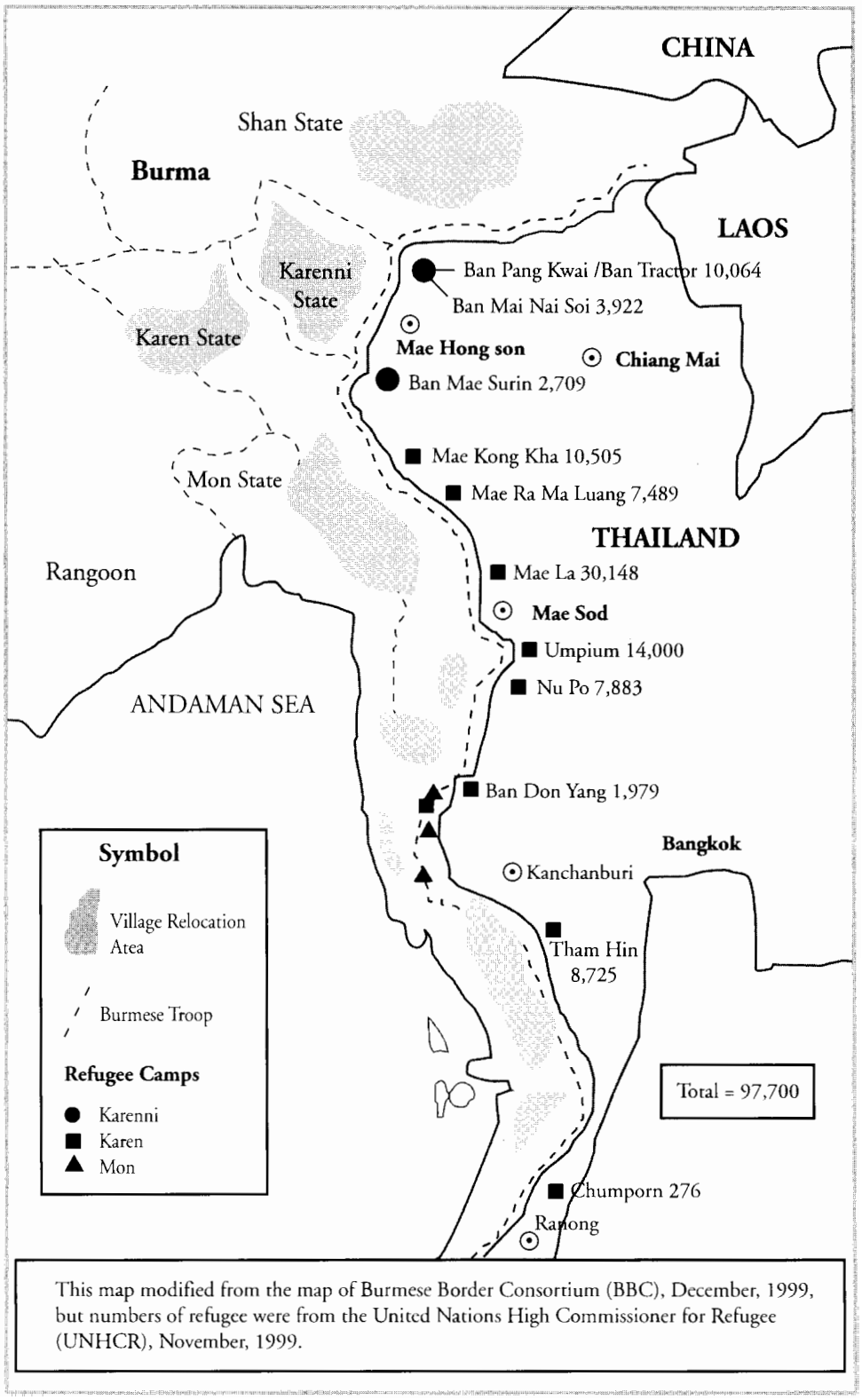
Consequently, in 1998, the Thai government invited UNHCR to take charge of the registration and supervision of 14 refugee camps[22] along the western border, from Mae Hong Son to Chumphon provinces (see Figure 3) and to facilitate repatriation. At a meeting that took place on May 15, 1998, the Thai government and UNHCR agreed upon the specific tasks UNHCR would be responsible for, including acting as observer to Thailand's assessment of whether to grant temporary shelter to refugees who were fleeing the fighting and effects of civil war. In cases where the relocation of temporary shelters was necessary, UNHCR was to support the Thai government's decision to relocate these shelters, as well as provide transportation, shelter materials, drinking water, perimeter fencing, and security infrastructure and registration. UNHCR was also to assist in organizing voluntary repatriation, with the consent of the Burmese government, and to monitor and facilitate the safe return and integration of refugees back to Burma.

3.4 Policy on Illegal Migrants from Burma

Since the Burmese government's suppression of the pro-democracy movement in 1988, hundreds of thousands of have fled Burma to Thailand. In the late 1980s, the Thai economy was in great need of unskilled labor. Private businesses worked hard to negotiate, demand, and pressure the Thai government to permit the use of foreign labor. The Thai Chamber of Commerce, which had joined forces with the Federation of Thai Industry and the Thai Banking Association, made continual demands until the government agreed to a more flexible policy toward migrant laborers. As mentioned earlier, under Article 17 of the Immigrant Act 2522 B.E. (1979), illegal migrants can work temporarily under conditions set by the government. This flexible policy maps out guidelines for registering illegal migrants that are then implemented through a Cabinet resolution. Between 1992 and 1999, four Cabinet resolutions on migrant labor policy were enacted.

22 The number of camps was reduced to eleven by the end of 1999.

Figure 3 : Refugee Camps along Thai-Burma Border



3.4.1 The March 1992 Cabinet Resolution

The first steps to expand the foreign migrant labor force began in 1992, when the Thai government passed a Cabinet resolution on March 17, 1992. This resolution allowed temporary employment of foreigners who were displaced persons or illegal migrants of Burmese nationality. Employers were required to report their employees to the local authorities. The migrant workers had to apply for an annual work permit costing 1,000 baht and the employers were required to put down a 5,000-baht "bail" for each worker. This "bail" was to ensure that when work permits expired, employers would turn over their migrant workers to the immigration police and they would then have the "bail" refunded to them. Employment was only permitted in nine border provinces: Chiangrai, Chiangmai, Mae Hong Son, Tak, Kanchanaburi, Ratchaburi, Prachuap Khiri Khan, Chumphon, and Ranong.

The Cabinet resolution proved to be completely unsuccessful. Only 706 alien workers reported to the authorities. The employers blamed the high cost of the 5,000-baht "bail" as the main reason for an extremely low turnout. Most employers continued to hire illegal labor, preferring to occasionally pay "tea money" to the local police to prevent any possible arrest. A major debate took place at this time, as the resolution did not allow the hiring of migrants for fishery work since the Right to Fisheries in Thai Seas Act forbids any foreigner to work in this sector. This law was later amended to permit employment of migrant labor and became part of subsequent policies.

3.4.2 The June 1996 Cabinet Resolution

Due to the failure of the 1992 Cabinet resolution, large numbers of migrant workers were moving toward Thailand's inner provinces. Here again, the private sector called on the government to implement a broader policy that would also include a lower "bail" fee for each registered alien worker. The Cabinet eventually passed a resolution on June 25, 1996, allowing the employment of illegal migrants from Burma, Laos, and Cambodia to work on a temporary basis. This new resolution provided alien work permits for a maximum two-year period and extended the number of permitted work areas from nine to 43 provinces. However, only eight industries were open for registration, namely: agriculture, construction, fishery and its related industries, loading and unloading of ship cargo, mining, gem mining, manufacturing, and domestic help. These eight industries were further classified into 34 types of work. Migrants were thus allowed to work legally, provided they stay within the resolution's stipulated industries and provinces.

The registration procedure was completely left to the employers, since state policy expected employers to be held accountable for their migrant workers. Any employer wishing to hire migrant labor was required to submit guarantor papers to the provincial immigration police, along with a 1,000 baht 'bail' fee. Migrant workers were also required to have a medical check-up that cost 500 baht. After reviewing migrants' papers, including the results from the medical check-up, the Ministry of Labor and Social Welfare would grant a work permit for an annual fee of 1,000 baht. The total cost of registering a migrant worker was thus approximately 2,500 baht. Usually, the employers paid all of the expenses in advance and then deducted the costs from the workers' wages. Most employers kept the work permits themselves

for fear that the migrant workers would run off. Some employers would make a photocopy of the work permit for their workers, as proof of being registered. However, many registered migrant workers were arrested and deported as a result of not having official documents to show the authorities.

The migrants who were eligible to register for work permits were required to have been working illegally in Thailand prior to June 25, 1996. A 90-day registration period, from September 1 to November 29, 1996, was officially mandated for the migrants to file all of their papers, take their medical exams, and apply for their work permits. Due to the large number of migrants that chose to register, this first 90-day period was extended to March 1997. By May 22, 1997, a total of 303,088 alien workers were granted work permits. Of this number 263,782 were Burmese (87%); 12,323 were Laotians (4%); and 26,983 were Cambodians (9%). Most alien workers were registered in the construction industry (33%), followed by agriculture (28%), maritime fishery (18%), domestic help (12%), manufacturing (8%), waterway transportation (1%), and mining (0.5%)

3.4.3 The April 1998 Cabinet Resolution

The 1997 economic crisis in Thailand caused massive unemployment of hundreds of thousands of Thai workers. In an effort to address this problem, the government decided to repatriate the migrant labor force and replace it with Thai nationals. At a meeting held on January 15, 1999, the Illegal Labor Problem Solving Sub-Committee decided that 300,000 Thai workers would be hired in place of their migrant counterparts. Soon thereafter, widespread arrests of migrant workers occurred. By the end of July 1998, 249,817 illegal migrants had been deported (Office of the Immigration Bureau, 1998). The police, however, knew that such deportation would have only a slight impact since most deportees would simply cross back across the border into Thailand.

The private business community, which was profoundly affected by the deportation of these migrant workers, moved to oppose the government's policy, claiming that few employers could find Thai replacements. The Ministry of Labor and Social Welfare then proceeded to take surveys of the labor demand nationwide. These surveys revealed that 230,617 workers were needed, since, in fact, no Thai nationals were found to fill these jobs. Consequently, the government passed Cabinet resolutions on April 28, 1998 and May 8, 1998, which permitted the employment of illegal migrants for another year. This time, however, the resolution limited the number of workers to no more than 158,253. Only 90,911 migrants chose to register.

The conditions set forth in these resolutions were slightly different from those of the 1996 resolution. The types of businesses that could hire migrant labor were increased from 34 to 47, as were the number of provinces, which now totaled 54 (as opposed to 43 in 1996). Of these 54 provinces, 13 were along the border, 22 were engaged in the fishery business and 19 had labor shortages in industries such as rubber plantations, sugar cane farming, pig farms, rice mills, and waterway transportation. The registration period was set for 90 days and while the "bail" and work permit fees were still 1,000 baht each, the medical exam was increased to 700 baht. In addition, most provinces required migrant workers to purchase a Health Insurance Card that cost between 500 - 1,200 baht.

3.4.4 The August 1999 Cabinet Resolution

Registering illegal migrants soon re-emerged as an agenda item for the government since the work permits issued in 1998 were to expire on August 4, 1999. While key measures focused on arresting, deporting, and barring a flow of illegal migrants from entering the country, certain exempt measures were also enacted to ease the repercussions businesses were still experiencing from the Asian financial crisis. Migrant workers continued to be permitted to work in those provinces where Thai replacements were not available. The difference this time was that each province was given authority to determine its own needs. The Asian Migration Research Center of Chulalongkorn University conducted analysis of the labor demand in each province to determine the types of businesses, number of provinces, and number of currently registered migrant workers. These findings were then submitted to the Illegal Labor Problem Solving Sub-Committee and were later sent on to the Cabinet.

In August 1999, the Cabinet passed another resolution allowing 18 types of business (down from 47 in 1998) to employ migrant labor in 37 provinces (down from 54 in 1998). Ten of these provinces were situated along the border; 18 were engaged in fishery-related work; and nine of them were undergoing the process of developing production capacity. Initially, no more than 86,895 migrant workers were to be employed, but after negotiations with the private sector this number was increased to 106,000. The registration process was again to be completed within a 90-day period, with "bail" and registration fees remaining the same as in 1998. The medical exam was set at 700 baht and all migrant workers were required to purchase a health insurance card costing 1,000 baht. As of December 30, 1999, a total of 99,974 migrants had registered.

However, in 1999 measures to deport illegal migrants became increasingly more effective as compared to previous years, especially for migrants from Burma. This was largely due to an incident on October 1, 1999, when armed Burmese students seized the Burmese Embassy in Bangkok. The Thai government agreed to the students' demand to arrange for a helicopter to take them to the border province of Ratchaburi in exchange for the hostages' release. After this incident the government of Burma vented its anger at Thai authorities by closing all checkpoints along the border. Thai fishing boats were also banned from entering Burmese seas.[23] Deportation measures were stepped up in retaliation. From November 1 to December 6, 1999, following the completion of the 90-day registration period under the August 1999 resolution, immigration police deported a total of 75,315 alien workers, 70,835 of whom were from Burma.

23 In December 1999, the Thai Minister of Foreign Affairs visited Burma, which resulted in the re-opening of every border checkpoint. Thai vessels were also permitted to resume fishing in the Burmese seas. Moreover, it was the first time the government of Burma officially acknowledged that there were Burmese migrants working in Thailand. There is some hope that in the near future Burma will begin cooperating with Thailand to facilitate the safe return of these migrants. However, when this report went to press, no further talks on this issue had taken place.

Table 3.1: Number of Registered Illegal Migrants 1996, 1998, and 1999

Year	Type Of Work Permitted	No of Provinces Permitted	No of Migrants Registered	Country of Origin		
				Burma	Cambodia	Laos
CR in 1996	36	43	303,088*	267,782 (87%)	26,983 (9%)	12,324 (4%)
CR in 1998	47	54	90,911**	79,057 (87%)	10,593 (12%)	1,261 (1%)
CR in 1999	18	37	99,974***	89,318 (89%)	9,492 (10%)	1,164 (1%)

* The latest figure available, as of May 22, 1997, Ministry of Labor and Social Welfare.

** Under the 1996 Cabinet Resolution migrants registering with the authorities were given two-year work permits. In 1997, 88,644 migrants extended their permits. This figure when combined with the number of new migrants registering in 1998 totals 179,555.

*** The latest figure available, as of December 30, 1999, Ministry of Labor and Social Welfare.

Table 3.2: Number of Registered Illegal Migrants According to Nationality and Gender 1998 and 1999*

Year	Burmar		Cambodia		Looa		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
1998: Number	53,387	25,670	9,716	877	1,029	232	64,132	26,779
Percent	68	32	92	8	82	18	71	29
1999: Number	59,968	29,350	8,418	1,074	849	315	69,235	30,739
Percent	67	33	89	11	73	27	69	31

* Data on gender is not available in 1996.

3.5 Public Health Policy towards Migrant Workers

The massive influx of migrant workers posed serious problems to Public Health Service Administrations, particularly in border provinces where medical services were provided to thousands of migrants. These provinces faced shortages of medication and equipment for Thai nationals, which was then compounded when trying to service illegal aliens. In addition, the border provinces had insufficient medical welfare budgets. The number of clinic and hospital beds soon became limited, as more and more migrant workers began using these facilities. Such problems continue to be a burden for public health officials.

Based on humanitarian grounds, Thailand cannot refuse to care for these migrants. Yet, this means the government must shoulder ever-rising public health expenses. With the

backdrop of prolonged economic depression resulting from the Asian financial crisis, public health budgets, including funds for medication, equipment, and welfare services, have been slashed. In addition, a recent study showed that 36 Ministry of Public Health hospitals along the Thai-Burmese border had paid up to 50 million baht per year on medical treatment for migrant workers. (Pattarakulwanich et al., 1999)

Since 1996, when the number of provinces that could employ illegal aliens was expanded from nine to 43, some have criticized the government for not adequately adopting public health measures to cope with the burgeoning migrant population. Yet, the authorities have taken some basic measures, such as requiring a medical exam for those wishing to apply for work permits. These medical exams use the same evaluation criteria as the medical exams taken by applicants for official government positions. The criteria include disqualifying applicants who are diagnosed with one of seven contagious diseases.[24] In the effort to control many of these diseases, such as tuberculosis, leprosy, elephantiasis, syphilis, malaria, and intestinal parasites, the government prohibits migrants from working in the country who are potential carriers of these diseases, since they pose both a social threat and a financial burden to the government.

Another important public health measure adopted by the government, which was recently included in the 1998 Cabinet resolution, is the mandatory purchase of an annual health insurance card by migrant workers. This measure was initiated following demands by several provincial authorities that were concerned that the increasing number of migrants seeking health care was draining public health funds. To a certain extent, this measure has helped provide additional funds, while also alleviating some of the suffering of migrants who, in many cases, cannot afford medical treatment. However, based on the interviews conducted for this study, employers often keep migrants' health insurance cards to prevent them from running off or changing jobs. Consequently, this practice has limited the effectiveness of this policy.

The government has also recently initiated new programs in some provinces that provide family planning services and promote disease prevention and environmental sanitation. In addition, a procedure for observing contagious disease among the migrant population was established, as was a reporting system that tracks the spread of diseases, including contagious, venereal, and general diseases, within this community. These programs provide services to family members of migrant workers and to migrants who do not have work permits. The programs are targeted in areas where there are large communities of migrant workers who live together in the border provinces. However, these public health programs are unable to reach those who do not live clustered together or who must live in hiding, for fear of arrest.

In several border provinces where migrant workers have been employed long before the Cabinet resolutions, people from neighboring countries have received medical treatment or given birth at the public medical centers in Thailand. Some provinces have collaborated with

24 These diseases include (1) psychiatric problems or mental retardation, (2) acute tuberculosis, (3) active leprosy, (4) active elephantiasis, (5) tertiary syphilis, (6) drug addiction, and (7) chronic alcoholism.

NGOs in setting up clinics exclusively for migrant workers or implementing special programs to serve their communities and families. There are also health promotion outreach programs for certain occupational groups, such as the fishery and sex worker populations.

The Ministry of Public Health has also promoted self-care guidelines for migrant workers so that they can take care of themselves in cases of minor illnesses. In this way, they are not entirely dependent on doctors or public hospitals. However, in practice, such self-care is hard to implement since most migrant workers are not registered, have limited knowledge of their right to access health services, and face language barriers. Moreover, many live in hiding for fear of arrest.

Despite these obstacles, the Ministry of Public Health has sought to provide health services to migrant populations. However, problems still exist with regards to implementation, and often health officials at various levels do not fully embrace these policies. These officials need to recognize that they should not make a distinction between Thai and non-Thai patients, since the healthy well-being of migrant workers and other foreign nationals reduces the risk of contagious diseases spreading throughout Thai society.

3.6 Health Status of Migrant Workers

This section explores health status of migrants. First, migrants' morbidity and mortality patterns are reviewed. Second, some common contagious diseases among migrants from Burma are discussed. Spread of HIV/AIDS and other sexual transmitted diseases to migrant population are also examined. Finally, newborns and young children among migrants are considered in relation to basic health services and immunization against contagious diseases.

3.6.1 Morbidity

In 1997, among this population, an average of 2,000 individuals per month sought heath care. By 1998, this figure dropped to 1,710 and dropped again in 1999 to 1,021. It is claimed that this may be a result of efforts to increase the observation and control of diseases among migrants and foreigners who came to receive treatment in Thailand during 1997-1999. Nonetheless, this may be associated with decreasing number of migrants from 1997 to 1999 if number of registered migrants were considered (see Table 3.1). It is also likely to be a result of government instituted massive deportations in 1999 which created more fear to use health care services in public hospitals among migrants in 1999 than in 1997.

The major causes of illness did not change during the same three-year period. Malaria continued to infect over half of the migrant population and diarrhea affected approximately 15%-20% of the migrants. Ten to twelve percent experienced fever from unknown causes and contracted respiratory infections, such as tuberculosis.

3.6.2 Mortality

Malaria remains the major cause of death for more than half of the migrant population, followed by respiratory infections (pneumonia, in particular), tuberculosis, and acute diarrhea. Yet, this study found that accidents, especially from motorcycles and at the work place, were also a leading cause of death, second only to malaria. This finding corresponds with a study

Archavanitkul did in 1998. In addition, hospital officials have noted that migrant workers are often admitted to the surgery units of state hospitals at the provincial and community levels as a result of traffic collisions or other kinds of accidents. Motorcycle accidents often occur as a result of negligence or intoxication. Migrants' lack of knowledge regarding traffic laws and the Thai language puts them at high risk for road accidents. Similarly, most migrant workers have limited experience operating tools and equipment and are thus highly prone to accidents at their workplaces, such as the severing of fingers, burns from fire and chemical solutions, and falls from scaffolding or other high buildings. Moreover, most workplaces do not have adequate safety provisions for their employees. There have been cases where migrant workers have lost their lives from workplaces accidents or from infectious wounds that were not properly treated.

There have been a large number of deaths from unknown causes among Burmese migrants, which are often not recorded by the Ministry of Public Health. According to a foundation officer and discussions conducted with workers from Burma in Ranong, each month no less than one to three corpses of young men were found drifting along the coast. Of late, these incidents have occurred less frequently. Villagers in the area believe that the dead were fishing boat crew who had gone to sea for the first time and could not stand the hardship of a six to nine month stay away from land. Yet, many cases of unknown deaths of migrant workers also have occurred in the inner provinces. A director at a community hospital in Samut Prakan noted that in 1999, as many as 51 corpses of migrant workers were sent to the hospital for autopsies because the cause of death was unknown. These were mostly young men whose bodies showed no signs of being injured or wounded (Archavanitkul 1998). Some speculate that they died from exhaustion as a result of severe working conditions, similar to the 'sudden death while sleeping' syndrome, which has inflicted Thai workers in Singapore and migrants elsewhere in the world.

3.6.3 Contagious Diseases and their Impact on Disease Control

A number of contagious diseases found among migrants could severely affect the Thai populace. Diseases such as elephantiasis, meningococcus, plague, and polio, which at one time were nearly extinct in Thailand, pose serious threats once more. Meanwhile, malaria, acute diarrhea, and tuberculosis are on the rise among migrant workers and could easily spread throughout the country. Constant observation in certain migrant communities and follow-up treatment are desperately needed. However, in many cases, migrants do not remain in one place. They move to find new employment, often traveling outside of controlled areas, and sometimes to other provinces. This poses real difficulties to disease control, since most migrants do not inform the authorities when they move.

Based on data from the medical exams of migrants registering for work permits, approximately 1.5% - 2.0% suffered from illnesses that required medical treatment, while another 0.5% - 1.5% were diagnosed with contagious diseases, which prohibited them from obtaining work permits. In 1999, 402 migrant workers failed to pass their medical exam. These individuals were found to have drug addiction (171 persons), HIV/AIDS

(123 persons)[25], tertiary syphilis (42 persons), acute tuberculosis (42 persons), and active elephantiasis (24 persons).

Elephantiasis is currently one of the contagious diseases under the most constant and intense observation. According to a survey conducted from 1991-1993, within 94 urban towns in southern and central Burma, 1,663 people (2%) were diagnosed with microfilaria parasites (Thammapalo 1996). Microfilia parasite infection has been most prevalent among workers from southern Burma who migrate to the southern provinces of Ranong, Phang-nga, Phuket, and Surat Thani in Thailand.

Since 1996, the Ministry of Public Health took measures to dispense DEC (Diethylcarbamazine) to every migrant worker who came in for a check-up in the southern provinces were elephantiasis was spreading. These migrants were then requested to return every six months for additional medication. Yet, many of them were unable to come back. Therefore, the following year DEC was dispensed to every migrant who came in for a check-up and wherever migrants were identified for a mass treatment, all of whom were required to take DEC on the spot in front of medical officials. Some provinces sent mobile medical units into the housing areas and workplaces of migrant workers, with the cooperation of business owners or employers, especially in the provinces of Ranong and Phuket. According to random checks on migrant workers conducted by the Elephantiasis Division, the rate of filaria parasite infection was 2.65% in 1996. It declined to 0.79% and 0.36% in 1997 and 1998, respectively, and slightly increased to 0.46% in 1999.

Tuberculosis is another disease under intensive observation, as occurrences have increased markedly among both Thai nationals and migrants. Disease control, however, is very difficult due to crowded and musty housing, unattended garbage and waste, low standards of hygiene, and other environmental conditions. In addition, TB medication is very expensive. Moreover, it must be taken continually over a period of three to six months. Although effective medication that can cure TB in a shorter time period is available, the prices are exorbitant and, therefore, the government cannot dispense it to each migrant worker who seeks treatment. Workers diagnosed with myco bacterial infection, which is highly contagious, are especially watched and monitored for follow-up treatment. Unfortunately, however, language and communication barriers limit the effectiveness of these measures. A study in Tak province on migrants with TB positive sputum revealed that 70% of this group had not received proper medical treatment (Sawaddiwudhiphong et al. 1999). Accordingly, this group could easily spread the bacterial disease to many others since it is transmitted via breath. TB is likely to be a very difficult disease to control in the future.

Malaria is the most widespead of the contagious diseases and also the leading cause of death among Burmese migrant workers. In Thailand, there are three types of malarial parasites:

25 HIV/AIDS is not among the officially controlled diseases. However, in practice, authorities do test for HIV/AIDS during migrants' required medical exams and those found to be HIV positive are denied work permits.

P. Falciparum-PF, P. Vivax-PV, and P. Malaria-E. The prevalence rate of these among the Burmese migrant community is 61%, 39%, and 0.06%, respectively. Currently, some parasites, such as PF, have become resistant to malarial drugs, such that no type of drug treatment is effective, which is why malaria cannot be eradicated from Thailand. The spread of malaria is particularly evident in border provinces, such as Mae Hong Son, Chiangrai, Tak, Ratchaburi, Kanchanaburi, and some of the provinces in the South. If the PF-infectious patients do not receive treatment in time, they will likely develop acute symptoms and eventually die, often suffering from what is known as cerebral malaria. PV-infectious patients usually develop less acute symptoms, but the incubation period of the malarial parasite in the body is much longer.

Other Contagious Diseases: The Thai government currently has a policy to completely eradicate polio from the country. At the moment, the Ministry of Public Health uses an oral polio vaccine, which it administers through a 100% cover rate strategy. This means that the strategy covers all children under the age of ten, among both the Thai and migrant communities. Vaccines are administered at least twice a year. Campaigns to promote polio vaccinations are more intensive in the border areas. While it is expected that this program will result in 100% prevention against polio among Thai children, completely eradicating polio among migrant children is less likely because of the mobility of this population.

A study by Watthanasri and her team (1998) on hepatitis viruses among migrants in Ranong found a hepatitis B infection rate of 67.1% and a carrier rate of 12.7%. Such rates are comparably higher than the 1.7% infection rate among Thai nationals in the same area, suggesting that controlling hepatitis B is likely to be a formidable problem for Thai authorities in the future.

Contagious diseases tend to spread through contaminated water and food sources, especially in communities with low standards of sanitation. The working and housing conditions of migrant workers foster the spread of diseases, particularly because workers must live in small, crowded rooms, where often a number of them take turns using the same bed or sharing it with others. In addition, areas around housing units for migrants are filled with garbage, refuse, and unattended sewage, which become flocking places for a variety of animal carriers of contagious diseases.

3.6.4 Venereal Disease and the Spread of AIDS

In the past few years, the spread of AIDS among refugees in border areas, especially along the Thai-Burmese border, has become a growing concern. This virus cannot be controlled like the others since it is largely transmitted through sexual behavior.

Studies have found that HIV/AIDS infection is increasing on both sides of the border. HIV/AIDS infection has spread quickly in high-risk environments where a large number of migrants have settled. As shown in Table 3.3, HIV/AIDS infection rates in the border areas of Burma and Thailand considerably higher than other areas of either Burma or Thailand. According to Bennett (1997), such risk environments include areas where there is:

1. intense trade and investment with high money circulation;
2. an increase of sex entertainment establishments;
3. a lack of behavior control from society and/or family (e.g., since most migrant

workers leave their families behind and are mostly male and single, part of their wages is often spent on sexual services and alcohol);
4. cross-culture and language differences; and
5. ineffective enforcement of regulations and laws (especially in border areas).

Table 3.3: HIV Infection Rates Among Pregnant Women Along Thai-Burmese Border Provinces, 1994-1996

HIV infectioon rates	1994	1995	1996
Thachilek Province of Burma	8.4%	7.5%	7.5%
Chiangrai Province of Thailand	6.1%	8.4%	7.9%
Kawthaung Province of Burma	6.4%	6.7%	4.6%
Ranong Province of Thailand	3.8%	3.6%	2.7%
Whole Country: Burma	1.6%	1.5%	1.3%
Whol Country: Thailand	1.8%	2.3%	1.6%

Source: Bennett 1997.

Over the past five years an increasing number of young female migrants have entered the sex trade, both in the border and interior provinces, as well as abroad. Sex establishments have particularly increased along the border, especially in Mae Sai District of Chiangrai province in the north and Ranong Province in the south, which cater to both Thai and Burmese clients. In addition, many of the sex workers are trafficked or held in conditions where they are denied their basic rights and where they often face increased exposure and vulnerability to HIV/AIDS (Archavanitkul and Koetsawang 1997). HIV-infection rates among sex workers in these two provinces are very high. For example, the rate in Tak Province in 1994 was 20-25%, and 64 % in Ranong. A low rate of condom use among men in these areas has increased the ongoing risk of HIV/AIDS to sex workers and their clients.

Fishery is another industry that poses a high risk of contracting AIDS. According to a study in Ranong by the World Vision Foundation, drug use via intravenous injection was reportedly high among migrant workers returning from long trips to the sea. After receiving their wages, many purchased alcohol and sex. In addition, sex workers have been reported to work on many of the fishing boats while out at sea for extended periods of time.

Data from migrants' 1998 work permit medical exams confirms that sexually transmitted diseases, such as syphilis increased to 44% from 24% registered during medical exams the previous year. Venereal disease was also frequently found among migrants in Phuket, Samutsakhon, Trat, Surat Thani, and Pattani. The majority of these individuals were employed as fishing crew. Statistics from Ranong also revealed that among migrant workers, rates of AIDS infection have increased every year since 1993.

3.6.5 Birth

A study by Archavanitkul and her team (1997b) estimated that on average at least 2,000 babies are born to migrant workers each year. The total number of births in public hospitals from 1992-1996 was 6,209, of which the largest number were those of Burmese nationality, seconded by Laotian. The number of Cambodian and Vietnamese newborns was very small.

Controlling contagious diseases among children has been a key public health problem for the authorities. Increased vaccine administration would help immensely, since most children born of migrant parents do not receive any, or receive incomplete immunizations. These children tend to move from place to place with their migrant parents, making it difficult to administer complete immunization vaccines. If vaccine administration is not more broadly applied, diseases such as tuberculosis, diphtheria, pertussia, tetanus, Japanese E., encephalitis, mumps, and measles may return to pose serious health problems in areas where large numbers of migrants live. Expanding outreach measures is highly recommended, especially measures similar to those in Ranong and Phuket where immunization and general health concern programs are directly introduced into areas with large migrant communities. In addition, programs should be designed to provide information on birth control and family planning in order to prevent unwanted pregnancies, since the problem of high birth rates is largely due to the fact that most migrant workers are of reproductive age and lack access to family planning services. These programs could also provide a means for addressing the high rates of abortions found among migrant workers in this study.

4. Concluding Remarks

This chapter has reviewed two main issues among undocumented migrants from Burma: the Thai state policy on illegal migration from Burma and the health status of migrant workers. A massive influx of undocumented migration from Burma to Thailand has started since early 1970s due primarily to armed conflict between the government of Burma and minority armed forces as well as repressive policies and economic hardships in Burma.

Thai government policies related to undocumented migration from Burma have changed markedly over the last three decades according to changes in their approach to national security and Thai-Burma relationships. During 1970s and 1980s, most of migrants settled in the Thai border provinces. After the government of Burma's suppression in 1988, hundreds of thousands of people from Burma fled to Thailand and spread throughout whole country of Thailand later on. Because of demands for unskilled labor at that time, the Thai government issued Cabinet Resolutions (from 1992-1999) to provide a more flexible immigrant labor policy. These resolutions basically allowed employers to legally register migrants for specific jobs according to the type of industry and the province.

The Thai government official estimate of undocumented migrants from Burma in Thailand is approximately 600,000-800,000, including about 100,000 refugees housed in 11 temporary shelters. It is apparent that the large number of migrants pose serious problems to

the public health service administration, particularly in border provinces where migrants have been employed long before the Cabinet Resolutions. The major causes of illness and death among migrant population were malaria, diarrheas and respiratory tract infections. Other contagious diseases commonly found among migrants were elephantiasis, meningococcus and plague. It seems that migrants were also vulnerable to some communicable diseases, such as hepatitis virus, venereal diseases and HIV/AIDS.

The Ministry of Public Health has sought to provide health services to migrant populations. However, problems still exist with regards to implementation, and often health officials at various levels do not fully embrace these policies. Efforts must be made to discourage officials from making distinctions between Thai and non-Thai patients, since the healthy well-being of migrant workers and other foreign nationals reduces the risk of contagious diseases throughout Thai society.

My family members were all farmers. Some years we could earn enough, but in other years we could not and went into debt. We had to give our rice to several rebel groups and the Burmese collected too much and too many taxes. The Burmese soldiers always forced us to do many things, such as building military camps, fixing roads, and being porters for their armies without anything in return. We did not have enough time to do our own work. That was why we decided to come to Thailand.
(Shan man, age 40,
construction worker in Chiangmai)

Chapter 4
Profile of Migrants from Burma in Thailand

This chapter presents a profile of the participants in this study, based on surveys carried out in Chiangmai and Ranong and data collected from in-depth interviews and focus group discussions conducted in Chiangmai, Ranong, and Mahachai. Participants' responses and discussions are analyzed according to: (1) demographic background; (2) life in Burma; (3) migration to and mobility within Thailand; and (4) life in Thailand. A complete summary of these areas of analysis is provided at the conclusion of this chapter.

4.1. Demographic Background

4.1.1. Ethnic Composition

Burma, with a population of 47 million, is a nation rich in cultural diversity, comprising eight major ethnic groups, and over a hundred languages and dialects. The participants in this study reflect some of this diversity. All three study sites, Chiangmai, Ranong, and Mahachai, contain different ethnic compositions, including Shan, Burmese, Tavoy, Mon, Karen, Lahu, Arakanese, Garuka, and Indian. However, the ethnic distribution of the participants does not correlate with the total number, or represent all, of the ethnic populations that migrate to Thailand.

Table 4.1 below provides a break down of the ethnic distribution of the participants at the Chiangmai and Ranong sites. The number of study participants in Mahachai were too small to include statistically,[26] and generally followed the trends outlined in Ranong. As was

26 Given the sensitive political situation in Mahachai at the time this study was undertaken, no surveys were conducted, as they were in Chiangmai and Ranong.

noted in Chapter One, the political situation at the time of data collection prevented the researchers from conducting a survey at Mahachai, only in-depth interviews and focus group discussions were carried out here. The ethnic make-up in Mahachai was largely Burmese and Mon, with one participant each of Tavoy, Garuka, and Indian decent. Throughout this report, Mahachai is only noted when its findings differ significantly from the other two sites.

Table 4.1: Percentage Distribution of Participants According to Ethnicity

Ethnicity	Ranong	Chiangmai
Dewai	42.8	0.0
Burmese	41.1	0.7
Shan	0.2	96.3
Mon	12.0	0.0
Karen	1.7	0.7
Kachin	0.2	0.7
Others	1.9	1.5
Total: Percent	100.0	100.0
Number	418	409

The majority of the Chiangmai participants (96%) were Shan, an ethnic group that represents the largest proportion of migrants from Burma who enter Thailand. Lahu, Pa-O, Lisu, and Burmese make up the remaining 4%. Thailand has some of the same ethnic populations as Burma, and, in fact, the Shan spoken language and culture is very similar to that of Northern Thais. The Burmese, who represent the ethnic majority proportional to the population size of Burma, and the Dewai comprise 41% and 43%, respectively of the study's Ranong participants. Most of these two majority groups were of Tavoyan descent, originating from the Tenassarim region. The Mon made up 12% of the Ranong sample, and the other ethnic nationalities, such as the Karen and Arakanese, the remaining 4%.

The ethnicity of the participants at each site was closely related to the particular areas that correlated with the route migrants use to enter Thailand. In Chiangmai, as noted above, almost all of the participants were Shan and crossed the border from the Shan State into Thailand. In Ranong, migrant workers came from many different parts of the country: 70% came from Tennaserim and the Rangoon Divisions in Central Burma, 23% from the Mon State, and 6% from the central Burma divisions, such as Pegu and Mandalay (data not shown). Nearly all the Ranong participants entered Thailand through the Kawthaung-Ranong border crossing in the south, which is the area along the border that is predominantly Burmese in ethnicity.

4.1.2. Religion

Almost all of the participants in the study proclaimed Buddhism as their religion (97%). The remaining 3% were Christian, Moslem, and Animist. The majority of Burma's population practices Buddhism (89%), particularly the Shan, Burmese, and Mon ethnic groups (Economic Intelligence Unit 1998), all of which are represented by the participants in this study. However, the practice of Buddhism of each ethnic population differs to varying degrees in the style of their temples, manner of worship, and cultural interpretations.

4.1.3. Age

Only migrant workers between the ages of 15 and 50 were asked to participate in the study, since this span of years correlates with a person's reproductive years. The mean age of the study population was 27.5 years, with no significant differences between Ranong and Chiangmai participants or between women and men.

Table 4.2: Percentage Distribution of Participants According to Age Group

Age Group	Ranong		Chiangmai	
	Women	Men	Women	Men
15 - 20	18	10	15	15
20 - 29	45	53	47	49
30 - 39	26	31	29	27
40 - 50	11	6	9	9
Total: Percent	100	100	100	100
Number	210	208	218	191
Mean age	27.8	27.3	27.5	27.4

4.1.4 Educational Status in Burma

The participants' level of education differed significantly between study sites and gender, as demonstrated by Table 4.3. The participants at the Chiangmai site had the highest proportion of individuals who never attended school. Of the female participants, 38% had never received any schooling, as compare to only 5% of the female participants at the Ranong site. Among the male participants in Chiangmai, 12% had no schooling, and 35% were only exposed to education through Buddhist monasteries. In Ranong, however, only 2% of the male participants had never been to school, and 10% had received monastic schooling.

The participants' level of education reflects the inequity of the existing educational system in Burma. The lower educational status of the Chiangmai participants was, in part, attributed to their rural, agrarian-based origins (75% came from rural areas, as compared to

58% of the Ranong participants). It also reflects the limited access to education in Burma for ethnic nationalities because of lower investment in the infrastructure in the ethnic minority regions, as well as language barriers (classes are taught in the central Burmese language that has no similarities to most minority languages). Male participants were generally more educated than their female counterparts. In Ranong, every level of education, with the exception of primary school, had a higher proportion of men than of women. Surprisingly, in Chiangmai a greater percentage of female participants (8%) reached high school than men (2%).

Table 4.3: Percentage Distribution of Participants According to Years of Schooling

Years of Schooling	Ranong		Chiangmai	
	Women	Men	Women	Men
No schooling	5	2	38	12
Monastery	2	10	2	35
Primary (1-4)	53	32	30	28
Secondary (5-8)	32	36	21	23
High school (9-10)	6	17	8	2
Technical/university	1	3	1	0
Total: Percent	100	100	100	100
Number	210	208	218	191

4.1.5. Marital Status

In the migrant communities, as in larger Burmese society, marital status was predominantly determined socially, rather than legally. Twenty-eight percent of the participants never had been married. Of those who had been married (n=595), 78% currently lived with a spouse, approximately 10% lived away from their spouse, and another 10% considered themselves separated or divorced. Only 3% had been widowed (this relatively small percentage is due largely to the study's exclusion of migrants over fifty years old.)[27] Male and fema migrants exhibited significant differences with respect to marital status. Men were about three times as likely as women to be 'unattached.'

27 According to the UN Human Development Report (1998), life expectancy in Burma stands at 58.9.

The survey data suggested a strong association between the marital status and occupation of the migrants, particularly the women (Tables 4.4 and 4.5). In Chiangmai, service sector jobs had the highest proportion of unattached women, at 50%; the women in these jobs were 3.2 and 5.7 times as likely to have had no spouse living with them as the women in factories and in construction, respectively. In Ranong, women in fish processing factories were 5.5 times as likely as women in sawmills and 8.3 times as likely as women in plantations to maintain an 'unattached' status.

Table 4.4: Percentage Distribution of Participants According to Marital Status and Occupation *(Ranong)*

	Saw Mill		Plantation		Fish Processing	
Marital Status	Women (n=78)	Men (n=67)	Women (n=57)	Men (n=44)	Women (n=84)	Men (n=88)
With Spouse	81	51	88	31	43	25
Unattached*	19	49	12	69	57	75
	100	100	100	100	100	100

Table 4.5: Percentage Distribution of Participants According to Marital Status and Occupation *(Chiangmai)*

	Factory		Construction		Service	
Marital Status	Women (n=41)	Men (n=49)	Women (n=120)	Men (n=109)	Women (n=52)	Men (n=29)
With Spouse	70	43	85	57	50	31
Unattached*	30	57	15	43	50	69
	100	100	100	100	100	100

*Unattached includes (i) those who have never been married, (ii) those who married but live separately from their spouse, and (iii) those who are divorced or widowed.

According to the key informants, each type of occupation had its unique living and working arrangements which reflected the employers demand for single or married women and the choices migrants made based largely on issues of safety. Unattached women were typically sought for jobs in the service sector (where they were expected to live with the employer's family) and in factories (which often had accompanying dormitories requiring small groups of employees to share the same room). These arrangements were not conducive to married couples or families. In addition, unattached women in these jobs were selected by employers who preferred to hire workers with fewer outside obligations and responsibilities. They were, therefore,

perceived to be more productive (less likely to be absent from work to care for spouse and/or children), and more flexible with respect to working hours.

In contrast, construction sites, plantations, and sawmills had small one-room housing units for each family. These living arrangements were considered 'unsuitable' and unsafe for single women, according to the participants. Therefore, women in these work places were more likely to have a partner currently residing with them. In fact, the key informants and women themselves explained that in these circumstances they were better off married, citing safety and security as common reasons for getting married once in Thailand. In addition, many employers of these industries preferred married couples as they provided some stability and support in an environment of predominantly unattached men.

It is worth noting that the majority of participants who married did so by the age of 20. In Ranong, 56% of the participants were married by the time they were 18 years old, with 79% reporting having been married for the first time by the age of 20. The age of marriage among migrants in Chiangmai was generally higher than the other sites, 52% of the Chiangmai participants reported marrying for the first time before the age of 20 and half of them married before they were 18 years old (26%). Most marriages took place by the time the participant was age 25 (in Ranong, 95% and in Chiangmai, 85%). The majority of participants who reported marrying said they did so because they were in love (71% in Chiangmai and 85% in Ranong). Although a number of migrants explained that their marriages had been arranged (14% in Chiangmai and 8% in Ranong). There were no significant gender differences in these responses. However, migrant women also reported marrying for safety reasons or because they were forced (4% in Chiangmai and 2% in Ranong).

4.1.6. Fertility

Table 4.6 shows a significant difference between the average number of children born to migrants in Ranong (2.57) and to migrants in Chiangmai (1.74). The average number of children among all participants was 2.09, which is much lower than Burma's overall fertility rate of 3.5 (Human Development Report, 1998).[28] Though the majority of participants (40%) had an average of about two children currently residing in Thailand, many had left children with relatives back in Burma or along the border. This was explained in the in-depth interviews and focus group discussions as a better option for their children, given the unsanitary and unsafe conditions of the migrants' work and living environments, as well as the lack of educational opportunities.

28 Migrants who participated in the in-depth interviews explained that this was the result of easiet access to contracep tives in Thailand. This will be discussed in more detail in Chapter 7.

Table 4.6: Average Number of Children Born and Number of Children Still Alive

Average Number of Children	Ranong	Chiangmai	Both Sites
Born	2.57	1.74	2.09
Still Alive	2.30	1.72	1.98
Living in Thailand	1.31	1.14	1.22
Living in Burma	0.99	0.58	0.77
Number	244	301	524

4.1.7. Number of Years Since First Migrating to Thailand

To participate in this study, the migrants had to have left Burma for the first time in or after 1988.[29] Half of the participants had left their homeland within the last three years. On average, they had arrived in Thailand approximately 3.8 years prior to being interviewed for this study (Table 4.7); in Ranong, they came, on average, about 6 months (0.5 year) earlier than migrants in Chiangmai ($p < .01$, CI= .185, .858). A significant difference between men and women did not exist.

Table 4.7: Average Number of Years Since First Migrating to Thailand

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Mean	3.3	3.4	3.3	3.7	3.9	3.8
Median	3.0	3.0	3.0	2.0	3.0	3.0
Std. Deviation	2.6	2.8	2.7	2.2	2.1	2.2
Number	210	208	418	218	191	409

4.2. Life in Burma

Life in Burma for the majority of the participants was described as arduous and harsh. Deteriorating economic conditions and continued repression by the Burmese government and ongoing military conflict has hit hardest on the poor, particularly in the ethnic minority areas (Economic Intelligence Unit, 1998, The Burma Project, 1998). The following sections examine the socio-economic status of the participants (income and occupation) in Burma and their reasons for migration.

29 The rationale for this ten-year limit is provided in Chapter 1 (Section 3).

4.2.1. Occupation and Income

The vast majority of participants reported owning their own land (80% in Chiangmai and 95% in Ranong) and earning an income (73% in Chiangmai and 78% in Ranong) before they left Burma, while a quarter of them (n=203) were primarily supported by their parents (78%) or spouse (12%). Between 20 to 40 percent of the participants reported earning less than 1,000 kyat (US$3) per month in Burma, with 51% earning between 1,000-5,000 kyat (US$15).[30] The value of this income can be better understood by examining it in comparison to the price of basic commodities at the time this study was conducted. For example, a half sack of rice (approximately 78 pounds), which usually feeds a family of four for three to four weeks, cost 3,500 kyat (approximately 3 months salary) and 3.5 pounds of oil cost 550 kyat (approximately half a month's salary). Migrants reported that inflation, taxation, and instability further exacerbated their low incomes.

Table 4.8: Percentage Distribution of Participants According to Monthly Income and Occupation in Burma

Monthly Income (Kyat)	Ranong			Chiangmai		
	Farm Work	Non-Farm	Gov't Official*	Farm Work	Non-Farm	Gov't Official*
1-1,000	24	19	67	50	16	18
1,001-5,000	62	58	33	47	63	64
5,000-10,000	12	18	0	0	1	18
Over 10,000	2	5	0	0	1	0
Total: Percent	100	100	100	100	100	100
Number	134	214	18	302	95	11
% in Farm work	74%			39%		

* Including state employees and soldiers.

30 Based upon the official exchange rate of August 1998, US$1=6 Kyat, which is considered overvalued by more than 5,000% (The Burma Project, 1998). As of mid-1998, the free market exchange rate stood at approximately US$1=330 Kyat.

Seventy-four percent of the Chiangmai participants (predominantly from the Shan State in Burma) had been involved in farming and plantations prior to migrating to Thailand, compared to 39% of those at the Ranong site (Table 4.8). The Ranong participants reported a broader range of occupations prior to leaving Burma than those in Chiangmai. Among the Ranong participants, the men had earned their livelihoods in Burma as fishermen (10%), vendors (9%) and day laborers (12%), whereas women sold food (30%), and held odd jobs (11%).

4.2.2. Reasons for Migrating to Thailand

Migrants noted that due to harsh economic conditions and threats to survival, they looked to Thailand for an opportunity to obtain security and sustain a livelihood. During the in-depth interviews and focus group discussions, migrants at all three sites spoke about why they migrated. While the specifics differed at each site, economic conditions were a prime, motivating factor, though these conditions were often discussed in terms of the political context. The recognition of the interconnectedness of political and economic factors meant that the migrants did not see a distinction between labels such as 'refugee,' 'displaced person,' or 'economic migrant.' All of the participants described their reasons for migrating in terms of economic opportunities, but often went on to describe why the political situation prohibited their ability to prosper at home.

Although, all the participants noted economic hardships, the circumstances that precipitated their migration differed at each study site. For instance, the Chiangmai participants, who were predominantly from the Shan State, reported incidences of violence and/or coercion that prompted them to migrate to Thailand.

My family members were all farmers. Some years we could earn enough, but in other years we could not and went into debt. We had to give our rice to several rebel groups and the Burmese collected too much and too many taxes. The Burmese soldiers always forced us to do many things, such as building military camps, fixing roads, and being porters for their armies without anything in return. We did not have enough time to do our own work. That was why we decided to come to Thailand.
Shan man, age 40, construction worker in Chiangmai

The Burmese and Shan soldiers started to fight in our area so we had to flee across the border, leaving a lot of rice behind. After about one month at the border, my husband and I came to Chiangmai to find work.
Shan woman, age 32, construction worker in Chiangmai

In Shan State life was miserable. Shan soldiers wanted recruits and Burmese soldiers sought porters. If you did not go, you had to hire some one to go in your place, especially as a porter. The Shan resistance army wanted to recruit my younger brother to be their soldier. They recruited boys as young as seven or eight years old. For these reasons, we decided to go to Thailand.
Shan man, age 24, construction worker in Chiangmai

Of course I would be happier in my own village and in my own environment. But there it was a never-ending cycle of living hand to mouth. We didn't earn enough to support the entire family. We couldn't live in peace either. They [the government] would come to ask every household to contribute labor about two or three times a month. Everyone, women, men, married, unmarried, all had to go. If we didn't, we would be fined, or we would be made to hire a replacement.
Tavoyan woman, age 31, working on a turtle farm in Ranong

Burmese politics is so confusing, and it was very hard to make a living in Burma. We were not allowed to stay in our village and could only go to work on the land in the afternoon. We were not allowed to stay late either. So, it was hard to make any money. Many people from our village were going to Thailand and we joined them. There were over 30 of us, including children.
Shan woman, age 34, construction worker in Chiangmai

We lived on our own land in Tavoy and yet we were always poor. The income from our business was very low, often lower than our cost of living. In addition, we were often told to contribute 3,000 or 4,000 kyat to construct roads or other community activities. Other times we were told to work on construction projects like roads. But, I had children and my husband wasn't home. So, I had to hire someone to go in my place. This cost between 3,000-7,000 kyat each time. We often had to borrow money to pay and ran up our debts as a result. Instead of earning a living we were falling into debt.
Tavoyan woman, age 21, farm worker in Ranong

We have a big house in Shan State. We have to pay property tax of 10,000 kyats each year for the house. Our family does not have that much money. I had to find money so that my mother could continue to live in her house.
Shan woman, age 45, construction worker in Chiangmai

The past ten years of my life have drifted away since the 1988 student uprising. I spent the first three years in jail and then five years in camps at the border. I have nothing to show and no improvement of my life. I have nothing for me, my parents, or my fellow men. Now my parents have suffered strokes and I cannot help them. I have to try and find work to build some sort of future.
Mon man, age 23, laborer in Mahachai

After the student demonstrations in 1988 the schools closed. They opened again for a short time and then were closed again. I had no educational opportunities, so I had to try to advance my life in other ways. Therefore, I came to Thailand to get some experience for my life.
Tavoyan woman, age 29, old farm worker in Ranong

4.3. Migration to and Mobility within Thailand

4.3.1. First Migratory Journey

The participants' descriptions of their first migratory journey into Thailand provided an important dimension in understanding their migration and decision-making processes. Participants were asked about the people who accompanied them the first time they migrated to Thailand, as well as the involvement of agents or brokers in arranging the trip and eventual employment, and the form of payment for the journey.

Several factors influenced migratory routes, such as social networks (family, friends, villagers), safety and convenience of travel, and the involvement of agents. Burmese from the Magwe and Mandalay Divisions migrated directly to Ranong, rather than to other parts of Thailand since it was a much shorter migratory route than Chiangmai or Kachanaburi. Proximity, however, did not invariably determine the point of destination for many of the other migrants. Maps 1.1 and 2.1 show the common migratory routes traveled by the participants, as well as the geographic divisions and ethnic composition of Burma.

Gender differences were stark with respect to traveling companions during the participants' first migratory journey. Sixty-five percent of all women migrated to Thailand with only their kin relations, and another 16% with both kin and friends, as compared to 30% and 12%, respectively of all men (Table 4.9). Men were most likely to be accompanied by non-kin relations (40%) (friends, neighbors, and villagers (or to have traveled alone (19%).

Table 4.9: Percentage Distribution of Participants According to Travel Companions on First Migratory Journey

Accompanying Persons	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
All-kin	74	32	53	59	28	44
Mixed	6	3	4	27	21	24
All Non-kin	16	38	27	13	40	26
Alone	4	27	16	1	12	6
Total: Percent	100	100	100	100	100	100
Number	205	205	410	218	191	409

Migration from Burma to Thailand often entailed the use of agents or brokers, individuals who were familiar with routes of travel, border checkpoints, and/or employment networks. Chiangmai and Ranong migrants differed greatly on the use of these individuals for their first migratory journey. An agent was involved with only 3.6% of the Ranong participants, but was an integral element to the migratory journey of 27% of Chiangmai participants (Table 4.10). While there were no apparent gender differences in Ranong, Chiangmai men were 3.5 times

more likely than their female counterparts to come with an agent. The difference in the degree of agent involvement between Chiangmai and Ranong participants may be a result of the conditions inside Burma and the geographic location of the two sites. To reach Chiangmai requires traveling through Burma and northern Thailand, along a route punctuated by checkpoints, border control, and fighting. In contrast, Ranong is situated directly across the border from the Burmese town of KawThaung, which is only a three-day boat ride from Tavoy and other major towns in southern Burma.

Table 4.10: Percentage Distribution of Participants According to Agent Involvement in their First Migratory Journey

Accompanying Persons	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Agent Involvement	3	4	4	16	39	27
No Agent	97	96	96	84	61	73
Total: Percent	100	100	100	100	100	100
Number	210	206	416	218	191	409

More men than women in Chiangmai relied on agents on their first trip to Thailand. This may be explained by the fact that many men initiated the migration journey before their family members. This was frequently reported as a means of establishing work and residence before calling family members to join them and, therefore, a greater need of an agent to assist settling in Thailand.

How the trip was paid for influenced the degree of mobility and autonomy that a migrant enjoyed in deciding place of employment and work contract. If the migrant became indebted to an agent, he/she was obligated to pay off that debt, often by working for an employer arranged by the agent. Among the study participants, very few became indebted during their first migratory journey. Overall, 75% of the migrant workers used their own money to pay for their first trip to Thailand. Although 15% of the migrants came to Thailand with an agent, only 2% of female migrants and 2.5% of the men admitted to being indebted to an agent during their journey (Table 4.11).

Table 4.11: Percentage Distribution of Participants According to Form of Payment for First Migratory Journey

Accompanying Persons	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Own money	73	75	74	80	83	82
Borrowed Money	16	11	13	17	7	12
Debt to Agent	1	2	2	2	3	2
Other*	10	12	11	1	7	3
Total: Percent	100	100	100	100	100	100
Number	210	208	418	218	191	409

* Includes travel expenses paid by family members or relatives.

In contrast to the experiences of those in Ranong and Chiangmai, in-depth interviews with participants in Mahachai revealed that the majority of these migrants had come to Thailand and found work through an agent. Mahachai participants' debt to these agents ranged from 2,500 to 12,000 baht. This debt was paid to the agents with interest from their earnings upon arriving in Mahachai. Some migrants reported being able to pay back their debts within several months' time, while others were still repaying their debts a year later.

I came to Mahachai with an agent. I had to pay 12,000 baht and stay with him until my debt was paid. However, because I came with an agent I did not have any difficulties in my travels here. Now I am using my earnings to pay for my food and my debt.
Mon woman, age 36, factory worker in Mahachai

The Mon agent brought my friends and I to Mahachai along with about 30 others. When we arrived he told us we each owed him 11,000 baht. We didn't have the money so we had to pay him from our earnings. It took me about three months to pay him back.
Mon woman, age 28, factor worker in Mahachai

I borrowed money from my relatives to go to Kawthaung. From there I met a Mon agent who charged 1,000 kyat to bring me to Ranong. He then introduced me to a Thai agent, who offered to bring me to a job in Mahachai for 2,500 baht. In all I owed 3,500 baht when I started my job.
Burmese woman, age 30, shrimp factory worker in Mahachai

An agent told me of work in Mahachai and I agreed to pay him the value of two and a half pieces of gold. It has been one year since I arrived in Mahachai and I am still trying to pay back my debt. The agent says I only have a bit left to pay.
Burmese woman, age 20, shrimp factory worker in Mahachai

Migrants in Chiangmai and Ranong reported incurring debts in order to pay for their travel to Thailand, but rarely involved paying agents to secure them jobs, unlike those in Mahachai. This may be due to the fact that Mahachai is deeper inside Thailand and not readily accessible from the Thai-Burma border. The Shan migrants interviewed for this study reported paying between 1,500-3,000 baht to travel from the Burmese-Thai border further into Thailand to find work. Some initially found low paying agriculture jobs at the border, whereas others came directly to work on construction sites in Chiangmai.

We came by car to Thailand. Because I had no money, a relative took care of all my travel expenses. The carfare was about 2,000 baht. As soon as I arrived, I got a job as a mason and later I paid all the debt I owed my relative with my wages. There were more than 20 people when we came and we were dead scared of the Thai police. We frequently made stops on the way to avoid them.
Shan woman, age 25, construction worker in Chiangmai

We didn't have money to go to Thailand so we borrowed money worth about one ounce of gold and agreed to pay twice the amount.
Shan woman, age 27, construction worker in Chiangmai

An agent brought me to Thailand for 30,000 kyat. I paid him in cash. But, when we got to Mahachai he explained that the money was only for the journey and that I had to pay him three months wages for finding the job for me.
Burmese man, age 22, factory worker in Mahachai

The study's findings indicate that the migratory journey to Ranong was relatively safe, which was not the case for most of the migrants (predominantly Shan) interviewed in Chiangmai. However, to varying degrees, fear and abuse were reported along all migratory routes.

On our way to Thailand we spent one night at the border. There was one man from our village, a girl about 11 or 12 years old, and a woman from Muang-Pan who came with us in the same group. She was about 19-20 years old. The Burmese soldiers took them to their camp up a hill. They asked questions and took away the man's Burma ID card and let him go. Then the girl came back, running down the hill crying. But the woman from Muang-Pan was detained all night. That night, the rest of us in our group secretly walked across the border along the jungle route, avoiding the Thai checkpoint. Then we came to a road where we boarded a car to Chiangmai.
Shan woman, age 32, construction worker in Chiangmai

Some guys would pick on me as I was travelling alone. I experienced a lot of belittlement. Despite all the fondling and harassment my heart has not changed.
Tavoyan woman, age 28, sawmill worker in Ranong

A number of the migrants spoke about the risks involved in illegal migration, such as vulnerability to being trafficked, exploited, and/or detained. During the in-depth interviews, the risk of being trafficked was specifically mentioned by many of the Ranong and Mahachai participants.[31]

Before I left Burma, I heard that some Burmese were sold. I haven't had this kind of experience. What I heard was that people can be sold into sawmills and fish packing factories. It was the Burmese selling Burmese. I was afraid of this, of course.
Tavoyan woman, age 33, sawmill worker in Ranong

People said that if I came here [Thailand], I would find opportunities to earn a good living. My parents did not want me to come. They said that people would look down on me because I am a woman, and that Thailand was not a good place for women -so many opportunities to get mixed up with men. Most of the girls who come from Burma have to work in restaurants and shops. These girls then have to have relationships with men. That's why, it was only after I got married, I came here with my husband. I can rely on him and, moreover, nobody will look down on me.
Tavoyan woman, age 25, sawmill worker in Ranong

I was afraid of being sold when I came to Thailand. I came to Ranong with an agent and he often told me to do what he says and don't run away otherwise you will risk being sold. I was so afraid.
Indian man, age 24, porter for a shrimp factory in Mahachai

I heard of women being sold into prostitution and problems with police in Thailand. But, I believed if I remained in my village I wouldn't get a better life. So, I came anyway.
Mon woman, age 16, farm worker in Ranong

Perceived benefits of migration, such as the ability to sustain a livelihood, often outweighed the risks, especially when the migrants had an existing network of family members and friends who were already in Thailand.

31 It should be noted that the findings from previous studies on trafficking found a higher percentage of Shan migrants, (particularly females) trafficked, especially into sex work (see for example Archavanitkul and Koetsawang 1997). The findings of perceived risk in this study, based on in-depth interviews and focus group discussions, need to be explored further given the possible bias in the semi-structured interview questions and cultural differences surrounding these issues.

4.3.2. Mobility

The study sought to understand the extent to which migrants moved and the impact of mobility on the individual, family and community. This insight offers insight into the migrant's vulnerabilities and how it influences their decision-making process. The study explored four types of mobility: (1) cross-border mobility, as measured by the number of times migrants returned to Burma; (2) intra-country mobility, as measured by the number of places migrants lived in addition to the Thai province where they currently reside; (3) local mobility, as measured by the number of places migrants lived within the Thai province where they currently reside; and (4) occupational mobility, as measured by the number of different occupations migrants held.

Cross-Border Mobility

Over half of the study's participants (56%) had not returned to Burma since their first arrival in Thailand. As is to be expected, the migrants who had been in Thailand for a longer period of time were more likely to have made the journey back home. Among those who had not returned, the mean number of years in Thailand was 2.7, as compared to 4.6 years among those who had gone back at least once. The extent to which participants returned home differed significantly between study sites, but not by sex. Ranong migrants had, on average, made 1.1 returns to Burma, which is significantly greater than 0.7 returns undertaken by their Chiangmai counterparts (Table 4.12).[32]

Table 4.12: Average Number of Times Participants Returned to Burma

	Ranong			Chiangmai			Both Sites	
	Women	Men	Total	Women	Men	Total	Women	Men
Mean	1.1	1.1	1.1	0.9	0.5	0.7	1.0	0.8
Std. Dev	1.8	2.3	20.	1.2	0.9	1.1	1.5	1.8
Number	208	204	412	193	179	372	401	383

These findings were not surprising given that the conditions precipitating migration for the Chiangmai participants, the majority of whom were Shan (96%), were more directly the result of violence and forced migration. Chiangmai participants also expressed more fear of persecution if they returned home, largely by the Burmese authorities, than did the migrant workers in Ranong.

32 The difference of 0.5 is statistically significant at $p < .001$ (95% CI: .27, .71).

However this [Thailand] is better in comparison with the situation in Burma, the wages are still enough to live on. We have been here for nearly a year and we have not been back. We have no idea how to earn a living if we go back, we have no farms and fields any more, and the Burmese authorities have confiscated all our property. And to work as a hired day laborer, we will not be able to earn enough to eat and work would not be available all year round.
Shan man, age 44, construction worker in Chiangmai

Now Thailand wants to drive us out. But, many of us could not repay our debts and have no money for the return trip. This is why so many people cannot go back home. If they have to go, those agents who brought them will follow them. How can they run away from their control? Also, they don't know the way back. They came by trucks with dark glass or loaded with produce, which they had to hide beneath. That's why many people cannot go back.
Karen woman, age 25, worker in a fish canning factory in Mahachai

We don't support my parents but we do support my in-laws. My in-laws face many difficulties. We cannot send money regularly. Whenever it's convenient, we do it. We go over to Kawthaung from here. There we exchange the money into Burmese currency and make a telegraphic transfer. There's a service called the 'forestry (department) telegraph', which makes transfers in one day. We have used this service. We don't have a person take the money for us.
Burmese woman, age 26, sawmill worker in Ranong

When I return the Burmese authorities will make note of it and I will have to pay all the back taxes and fees since I have been gone. For instance, if the levy is 700 kyat a month for someone to replace me as a laborer, next month I will have to pay 2,000 kyat. It's like this. When I return, I have determined that my fees will be about 15,000 kyat.
Tavoyan woman, age 28, farm worker in Ranong

I hear that the police in Burma will ask for 3,000 baht and arrest anyone who cannot pay. I worry about that. Those who can make money can pay, but those who don't, can't.
Mon woman, age 27, sawmill worker in Ranong

The in-depth interviews revealed that, in addition to limited returns to Burma, the migrants residing in Chiangmai and Ranong did not maintain close contact with their homes. About half of the participants in the in-depth interviews (n=75) had sent money back to Burma once or twice, but not more, since they first arrived in Thailand. This was a surprising finding because it contradicts a prevailing depiction of migrant workers as earning an income in a foreign land to support their family back home. The participants who did not send remittances home noted this was due largely to not having saved money, while some noted the lack of means to remit savings. Still others explained that their families or dependents were with them and no longer in Burma.

Intra-Country Mobility

To determine the degree of mobility migrants had within Thailand, participants were asked about the number of places they had lived outside the province where they were currently residing. Seventy percent of the participants had not lived anywhere else in Thailand other than their respective study site. Participants in Chiangmai had, on average, lived in 0.60 places in addition to their current provincial residence. In comparison, their counterparts in Ranong had lived in 0.34 additional places to that of Ranong province (see Table 4.13). Both Chiangmai and Mahachai are situated a good distance from the Burmese border, which may explain why migrants from these areas moved with greater frequency than their Ranong counterparts. The findings indicated that gender also affected the degree of mobility. In both Chiangmai and Ranong, men were more mobile within Thailand than were women. Men in Ranong and Chiangmai had, on average, lived in 0.4 and 0.7 places, respectively, whereas women in Ranong and Chiangmai had lived in 0.3 and 0.6 places, respectively.[33]

Table 4.13: Intra-Country Mobility According to Number of Places Lived In Addition to Current Provincial Residence

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Mean	.25	.44	.34	.46	.77	.60
Std. Deviation	.62	.97	.82	.93	.99	.97
Maximum	4	6	9	9	5	9
Number	210	205	218	218	191	409

For most migrants their decisions to move depended almost entirely on interactions with their agents, employers, and police officers, as noted below.

> *After working on farms at the border for several years we decided to go with a guide to Chiangmai to work on a construction site. We worked on one site, but the wages were not good so we moved to another. The employer did not pay us the full amount as promised. Therefore, I decided to go with others to look for work in Bangkok. I worked in a restaurant there for two months and then returned to find a construction job in Chiangmai.*
> Shan female, age 29, construction worker in Chiangmai

33 The gender difference in Ranong of 0.2 is statistically significant at $p < .01$ (95% CI: .04, .35) and in Chiangmai of 0.3 is statistically significant at $p < .001$ (95% CI: .13, 0.5).

We worked near the border for three months making and lining large pipes. After three months we hired a man to guide us to find our relatives in Chiangmai. We got work with them on a construction site for six months. But, the wages there were also bad. So, finally we moved to another site in Chiangmai. We have been here about one month and it is a little better now.
Shan woman, age 33, construction worker in Chiangmai

We worked all over Thailand. Our employer took us to so many places where we worked two to three months at each place. After he lost his job when the baht devalued, he told us to return to Chiangmai and gave each of us 400 baht for the bus fares.
Shan woman, age 19, construction worker in Chiangmai

When I first arrived in Thailand I worked in a pineapple-canning factory. They paid so low and the work was so hard I decided to leave. But then I got arrested. After I was released I was told about a job in the shrimp market in Mahachai. Since I have come here I have had to change my job three times. I moved twice because I was arrested and once because I did not like the way the owner treated me.
Burmese woman, age 37, informal health provider in Mahachai

I have been in Thailand for nine months. I had heard about this factory since I was in Burma, but have only been working here for four months. The reason is that when I first came to Thailand I was arrested and sold into the fishery business where I had to work for five months without pay.
Burmese man, age 30, shrimp factory worker in Mahachai

Local Mobility

The third dimension of mobility this study examined was movement within the respective province of each study site. Overall, about one-third of the migrants had lived only in one province in Thailand. However, there were significant differences between Chiangmai and Ranong regarding mobility within each province. Migrants in Chiangmai had, on average, lived in 3.6 places within the province, compared to 1.7 places lived by migrants in Ranong.[34] While the difference between men and women was not significant, gender influenced the mobility within the province of Chiangmai. Men in Chiangmai had, on average, lived in 4.0 places, compared to 3.1 places for their female counterparts (Table 4.14).[35]

34 The difference of 1.83 was statistically significant at $p < .001$ (95% CI: 1.51, 2.15).
35 The difference of 0.88 was statistically significant at $p < .01$ (95% CI: .26. 1.49).

Table 4.14: Number of Places Participants Lived within their Respective Provinces

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Mean	1.67	1.79	1.73	3.15	4.03	3.56
Std. Deviation	.88	1.23	1.07	2.93	3.39	3.18
Maximum	5	10	10	24	20	24
Number	210	206	416	218	191	409

Gender differences existed, with women frequenting places outside of their homes more often than did men. This was most likely due to women's responsibilities to shop and take care of children, since the majority of the trips were to the local market.

Although gender differences were marginal, data from the in-depth interviews, focus group discussions, and survey indicate that many participants did not leave their compound for fear of arrest. In both Chiangmai and Ranong, approximately one quarter of the participants had never left their residential compound except for work, and only 12% left their home two or more times during a week (Table 4.15). Women in particular expressed more fear of moving outside of their work or residential compounds.

Table 4.15: Percentage Distribution According to Frequency of 'Leaving the House'*

Frequency of 'Leaving the House'	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Never	16	33	24	24	24	24
Once a month or less	50	24	37	21	34	27
Once a week	269	23	25	41	34	38
Two to three times a week	4	11	8	9	6	7
Everyday	4	9	6	5	2	4
Total: Percent	100	100	100	100	100	100
Number	210	208	418	218	191	400

* Other than fot work.

Participants discussed gender differences in mobility both in terms of circumstances and cultural norms. Men confronted little or no social constraints on their mobility, whereas women reported facing greater perceived and/or real threats to their safety. Community perceptions about gender differences in vulnerability may explain the significant difference between women and men with respect to mobility.

I work quite far from where I am staying now. The employer comes and transports us to wherever he wants us to work each day. I leave my child with my neighbor and buy food on my way home from work. We cook and eat our food in our little room. No one would go anywhere even though our place is not far from town. We all just stay in the room and watch TV.
Shan woman, age 28, construction worker in Chiangmai

I have been in Thailand for two years. After work I just eat and sleep, and sleep and eat. I don't go out. I just stay here everyday.
Burmese woman, age 14, factory worker in Mahachai
I don't dare go out very much. It is not so safe for women. But my husband and his friends often go out.
Shan woman, age 27, construction worker in Chiangmai

I live in an all women's dormitory. I usually don't go out. I just go to work and come back. That's all. I have got no business to go around. Sometimes I pay a visit to my husband who works in a fertilizer company nearby, but not very often.
Mon woman, age 36, factory worker in Mahachai

There is a mobile shop that comes everyday to our orchard. The shop sells almost everything. We have only to pay once a month. We usually don't go anywhere even on Sundays.
Tavoyan man, age 18, farm worker in Ranong

We can roam around the plantation freely. But, women and those who do not have an ID card must fear the police. Our boss told us not to worry as long as we are on his land. But, at night we have to worry about the bandits.
Arakan man, age 36, cashew nut farm worker in Ranong

The men go out for a lot of drinking and merry-making over in Kawthaung. The women generally don't. They usually stay home and watch videos or sleep when they are free.
Tavoyan woman, age 37, sawmill worker in Ranong

The children have the hardest time because they also cannot go out and there is nothing for them to do on the construction site. I wish there were a teacher around here because none of the children here have any opportunity to learn.
Shan woman, age 34, construction worker in Chiangmai

The occupations available for migrants at each study site might explain differences in mobility between Ranong and Chiangmai. For example, in Chiangmai, those employed in the construction industry were more mobile than those who worked on plantations, or in sawmill or fishery industries in Ranong. Table 4.16 takes a closer look at the occupational variation of the participants.

Table 4.16: Mobility within Thailand According to Occupation

	Ranong			Chiangmai		
	Saw Mill	Plantation	Fishery	Factory	Constr uction	Service
Mean	1.8	1.9	1.6	3.4	3.8	3.2
Std. Dev	1.0	1.2	1.0	3.1	3.5	2.5
Maximum	6	5	10	20	24	12
Number	145	101	170	90	229	81

The differences in Ranong and Chiangmai were largely related to the living and work arrangements. In Ranong, migrants' residences were tied to their workplace, whether it was sawmills, plantations, or fish processing factories. As noted earlier, construction workers often moved with their new projects, and thus, their local mobility was relatively higher than those in other occupations. However, as Table 4.16 shows, participants' mobility across all occupations in Chiangmai was greater than all occupations in Ranong. Migrants who worked in factories had on average lived in 3.4 places, even though factory work is relatively stable. During in-depth interviews and focus group discussions many migrants explained that the reason they moved from one place to another was primarily a result of being harassed or cheated by their employer or work site supervisor.

> *The boss is really good and he pays us regularly. But, the middleman is cheating us. When we draw 100 baht he will put in the account books 1,000 baht. We never get all of our wages. For example, we work for three weeks and get paid for only two. We complain to the boss and sometimes we get the money back. Before they issued us work permits, but now they don't. Many of our friends have gone back.*
> Shan woman, age 27, construction worker in Chiangmai

> *We are always on the move, shifting from one place to another in search of good money and a boss who won't cheat us. The employers take our money. They are all the same. The only difference is how much they take. Once we were never paid for twenty days. So, we had to just move again to another place.*
> Shan woman, age 25, construction worker in Chiangmai

I was in danger from the gate guards. They always watched us on the payment days and tried to loot our money. I was scared and decided to move.
Burmese woman, age 30, shrimp factory worker in Mahachai

I worked at the shrimp factory for one month, but the employer cheated us on our wages. So, I left to work on the construction site. They cheated me too. I worked there for four months and was only paid for one. The Burmese cannot say anything, they have no rights. So, then I had to find another job.
Burmese man, age 22, factory worker in Mahachai

The employer was said to be a policeman, so we all were afraid. He paid us 3,000 baht a month. The first month was on time. But, after that sometimes he just took off 1,000 or 2,000 baht. Then we were not paid for six months. So, we had to escape.
Indian man, age 24, porter for a shrimp factory in Mahachai

Occupational mobility

The last form of mobility assessed involved the number of different types of occupations participants engaged in since first arriving in Thailand. Based on the findings, approximately half of the participants had engaged in only one kind of occupation, the one that they currently held. As regards those who held more than one occupation, men were more likely than women to have worked in two or more types of occupations (Table 4.17).

Table 4.17: Percentage Distribution of Participants According to Number of Occupations

Number of Types of Occupation	Ranong		Chiangmai	
	Women	Men	Women	Men
Only current type	62	49	54	48
Two different type	29	36	37	33
Three or more different	9	15	9	25
Total: Percent	100	100	100	100
Number	210	208	218	191

The average number of occupations differed slightly between men and women at both the Chiangmai and Ranong study sites. As Table 4.18 illustrates, male participants in Ranong had held 1.7 types of occupations, compared to 1.5 types held by their female counterparts.[36] In Chiangmai, male participants had on average worked in 1.9 types of occupations, compared to 1.6 types held by their female counterparts.

Table 4.18: Number of Different Occupations Held in Thailand According to Study Site and Gender

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Mean	1.49	1.73	1.61	1.58	1.92	1.74
Std. Dev	.72	.89	.82	.71	.97	.86
Maximum	5	5	5	4	5	5
Number	210	208	418	217	191	408

Migrants had different reasons for changing jobs as became apparent during the in-depth interviews, excerpted below.

In 1996, after we sent our elder daughter back to Burma, we went to Neyon to work in a 'packing' warehouse. After one month we came back here [to the sawmill], because the last employer did not allow female employees to live at the worksite. That would mean we would have to live separately and could not save much money. Also, if wives are not present, the husbands spend everything they make.
Tavoyan woman, age 25, sawmill worker in Ranong

At first I worked in an iron shop. Then I got a job at a gas station. But, the pay was so bad I moved to the fishing work. At that job I did not receive any pay at all so I moved again. Now at this job I also have yet to receive any pay.
Burmese, age 22, factory worker in Mahachai

I have had all kinds of jobs already. In the beginning I worked on a fishing boat and then I went back home because of some problems. I felt disappointed so I came back again. Since then I have had four different jobs. I was sold into my current job at the fishery after I was arrested about four months ago.
Garuka woman, age 38, fish canning factory worker in Mahachai

36 The difference of .25 was statistically significant at $p < .05$ (95% CI: .09, .40)

We wanted to try our luck in Chiangmai even though we knew it was a risk. We are always on the move, shifting from one place to another, in search of good money and a boss who won't cheat us. These people are almost all the same. They take your money. The only difference is that some take more and others less. Once we were never paid for 20 days. We moved to many places in Chiangmai before we landed here.
Shan woman, age 25, construction worker in Chiangmai

First I worked at a construction site digging ditches, but I had to move to another place because I had no ID card. At the second place there was no work for women, so we had to move again. We continue to move according to the work.
Shan woman, age 24 year, construction worker in Chiangmai

We shift from place to place looking for jobs. In some places I earn 80 baht and my husband 140 baht. In some places we stay for two months and if the wages are regular we stay a little longer.
Shan woman, age 25, construction worker in Chiangmai

4.4. Life in Thailand

This section examines the work and living conditions at each of the study sites: Chiangmai, Ranong, and Mahachai. It specifically looks at participants' income level, access to electricity and tap water, legal status, and assimilation into Thai society.

4.4.1. Chiangmai

The majority of the Chiangmai participants earned a living in the construction and service sectors, or by working in the night markets selling crafts and clothing to local visitors and foreign tourists. Construction workers resided on the work site in make-shift housing of corrugated tin. Others (factory workers and service providers) lived in private housing, or dormitories with rows of connected rooms often several stories high.

Construction Work

Migrants who reside in Chiangmai typically live on the construction site where they work. They bring their own food to the site, since the food available at the site is more expensive than at the nearby Thai markets. The workers rarely leave the construction site for fear of being arrested as illegal migrants. However, at times construction owners will transport the migrants to other sites for work. Typical working hours are from 7:30 a.m. to 5:00 p.m., with overtime continuing until mid-night, in some instances. Male migrants earn from 100-160 baht per day, while female migrants consistently earn less, approximately 70-110 baht per day. In several cases, migrant children are employed at even less pay than female workers. From these wages, deductions are usually made per month to pay for police bribes (300 baht), water and electricity (30-100 baht) and, for some, rent for their accommodations (as high as 500 baht).

The temporary tin housing is crowded, hot, and offers little to no privacy. There are no ceilings or windows and migrants have to leave their doors open in order for air to circulate.

All cooking, eating and sleeping takes place in the same small area. The migrants consistently complained about the lack of clean water and unsanitary conditions surrounding them. At all of the sites, participants complained of insufficient and filthy toilets, which were often located far from their living quarters. Some of the Shan migrants had obtained various types of Thai ID cards by registering as migrant workers together with their employer, or as an ethnic minority. Many tried to obtain such ID cards believing it would offer protection from arrest, but were cheated in the process or had the card disregarded by police officers.

Factories

Most small-scaled factories in Chiangmai that employ migrants hire between 30-40 workers. These workers most often live on their work site in row shacks similar to those of construction workers. They usually have access to electricity and water, which they do not have to pay for. These sites are often cleaner than construction sites, primarily because of the smaller number of residents and more permanent type of work. Factory compounds are typically guarded and migrants reported feeling safe as long as they stayed inside. The salaries of factory workers are in the same range as construction workers, though they are rarely offered overtime.

Service Industry

Migrants working in the service industry in Chiangmai had jobs as maids, shop tenders, gas attendants, or hawkers in the night market. These jobs were usually held by unattached persons between the ages of 14-30. The working hours are long and salaries range between 2,500-3,500 baht a month. Other than those working in the night market, migrants usually live at their employer's compound. The night market workers rent rooms, often sharing with two to three others. These rooms are quite clean with electricity and water and cost approximately 1,000-1,500 baht a month. However, the migrants who rent rooms complained about the lack of security. The risk of robberies is reportedly quite common.

4.4.2. Ranong

The migrants in Ranong live according to clearly demarcated ethnic lines. The port area, where the majority of them live, is situated several miles from the town center, which is predominately inhabited by Thais. 'Burma town,' as Thai nationals refer to it, is crowded, rife with filth and stagnant water, and permeated with smells of fish and shrimp paste. Outside of this town, Burmese migrants work on plantations, in sawmills, and in charcoal factories. These migrant communities live at their respective work sites, most often in housing provided by the employer. The communities are, in fact, compounds, often guarded, with restricted access.

Plantations

The plantations, located outside of Ranong, have from one to forty migrant families working on them, who live together in row houses in the middle of the plantation. Work begins early in the morning and continues through the evening. Most often, the whole family works together, each member with assigned responsibilities and chores, such as applying fertil-

izers and pesticides, watering, and clearing. Larger plantations that include rubber trees require workers to scrape the trees beginning around midnight until the early morning hours because the temperatures are cooler. One worker can scrape as many as 1,000 trees per day. The rubber 'juice' that oozes from the trees is collected and then taken to the processor in the early morning, where the rubber is mixed with water and acid, and then molded. After the rubber solidifies in the mold, it is pressed and dried. Rubber slabs come in thin rectangular pieces (approximately 18 by 24 inches). Workers are paid from eight to ten baht per kilo of pressed dried rubber. A migrant can earn over 3,000 baht per month in a rubber plantation.

The employers do not live on the farm or plantations. Some of the employers make daily visits while others come by infrequently. The head of the family, who is often the most senior worker, deals directly with the employer. This study found that few plantation workers were provided with work permits. Typically, the employer gives the workers a verbal guarantee of safety, on the condition that they remain within the compounds. On many of the plantations, a mobile market car makes frequent stops during the week, selling everything from vegetables to birth control pills.

Sawmills

Life and work in the sawmill compounds differs starkly from the small family plantations. The five sawmills that this study looked at employed from 50 to 300 workers. Within one compound are long rows of rooms, usually of wood or cement construction. Each family occupies one room. The mills are situated away from these rooms, usually in a separate section of the compound. Another section often includes the employer's or management staff's house/office. The residential section of the compound resembles a village, with vendors selling vegetables and meat, small stores offerings drinks, as well as snacks. In the larger mills, a barbershop and a video room are also available to the workers. Migrant women, whose husbands work on the logging boats or at the mills, often run these small ventures. They often compete with the shops managed and owned by Thai nationals.

The majority of workers at the mill are day-wage earners, especially the women. Only a few men receive monthly salaries and are able to secure work permits. Work at the mill encompasses varying levels of skill and responsibility. Women's work at the mill often entails binding up the finished boards and picking up and selecting leftover wood for charcoal making or crate making. Men's work, on the other hand, involves hauling the logs from the boat into the mill, measuring, and sawing them. The workers only earn an income when there is a supply of logs. When there are no logs, there is no work.

Fish Processing

Ranong has five major fish packing and exporting factories that each range from 50-400 employees. Each factory clothes their workers in color-coded uniforms, white hats to hold back women's long hair, short-sleeved, front buttoned shirts, usually of light color, such as pink, yellow, or sky blue, and matching dark pants that taper into plastic white boots. Women hanging from the back of pick-up trucks or mini-buses with their uniforms and lunch canteens are a common sight near the port area of Ranong.

Like the workers in sawmills, employees of fish processing factories are paid on a daily or piece-rate basis and their salaries depend on their own speed and amount of fish for processing. There are two main types of work involved in fish processing: (1) sorting seafood by size, quality checking, ice packing and (2) sorting packed sea food for export. Men dominate the first type of work, women the latter. Ice packing and sorting occur near the docks, where men await the day's catch with large steel blue drums. These drums are packed to the brim with ice and seafood - cuttlefish, squid, shrimp, and crab. The women work in shifts, some from 6:00 a.m. to 3:00 p.m., others from 3:00 p.m. to 9:00 p.m. Women and men alike in the fish processing industry live in the port area several miles away from the center of town. The employers arrange transportation for the female workers. However, not all the factories are located in the port area where most of the migrants reside.[37]

Overcrowding, filth, and an ever-present smell of fish are common features of the port area. For example, one of the homes observed by this study researchers housed 35 people. The situation would have been untenable except that they worked in shifts so not everyone was home at the same time. There are few single residential family units. Some of the migrants reside in makeshift huts and shacks, while others rent rooms in one-story buildings, resembling row houses. Each community embraces a diversity of people (workers, new migrants, those returning to Burma, fishermen, traders, sex workers) and every community has its own particular name.

4.4.3. Mahachai

Most of the migrants interviewed in Mahachai worked in factories, primarily processing fish, but also cloth, ice, and plywood. The majority of these migrants entered Thailand through the Three Pagoda Pass (Kanchanburi Province) or Mae Sot (Tak Province). They traveled from the border to jobs in Mahachai largely through agents who charged fees for both transportation and arranging employment. A striking difference between Mahachai and the other two study sites was that the majority of those interviewed in Mahachai were in debt to these agents and had to work for several months to one year to pay it off.

The fish processing factories in Mahachai are large and employ approximately 200 persons in each factory. In contrast, most of the other factories employing migrants are smaller, employing between 5-20 workers each. The working hours in Mahachai factories are typically from 8:00 a.m. to 5:00 p.m., often with overtime. Salaries range from 140-154 baht a day, with 28 baht an hour overtime.

Those working in larger factories typically rent their own rooms, together with others. There are long rows of rooms for rent often several stories high. As many as twenty persons stay in one room to save on rent and divide the living space with cloth. This often leaves each

37 Workers in these types of jobs were interviewed in their homes. It was not possible to interview at their work place because fish processing factories' employers impose strict rules on workers' conduct and time, and only pay workers by the amount of work completed.

person paying a few hundred baht a month for rent. Electricity and water are paid separately. There are also dormitories for females only. These dorms usually belong to the owner of the factory. The rooms are shared among four to six residents and rent is fairly inexpensive. The dorms have many rules restricting the hours of visitors and prohibiting any male visitors whatsoever. These dorms are considered safe for single women. Migrants who work in smaller factories, often live on the work site in rooms or shacks constructed out of tin sheets and wood. TVs, radios, fans, and rice cookers are often shared among those living together. The environment surrounding these living quarters is often extremely polluted, both with trash and open sewers.

The migrants interviewed in Mahachai came from a wide range of ethnic groups, including Burmese, Mon, Karen, Rakhine, Pa-O, and Shan. Not all the migrants could speak Burmese and there was often no common language among them. The rooms were often occupied by those who shared the same ethnicity and language. In addition, Thais also rented rooms in the same buildings, but often with fewer people sharing the quarters. Most people reported being afraid of arrest and violence and, therefore, did not go out much, but rather stayed in their rooms most of the time. While most felt confident that they could escape police, they feared loosing the possessions they would leave behind if they had to flee.

4.4.4 Income in Thailand

The majority of the study's participants resided and worked in Thailand without proper documentation and, therefore, fell outside of Thai laws that ensure labor rights and the mandatory minimum wage of 140 baht per day in both provinces.[38] At the time of the survey, 19% of the participants in Ranong and 5% in Chiangmai were not engaged in remunerated forms of work. In Ranong, 71% of the women as compared with 91% of the men had their own income at the time of the interviews, whereas in Chiangmai, there was no gender differential. Spouses financially supported the majority of the women with no income (80%), whereas friends supported the largest proportion (57%) of the unemployed men. A greater proportion of migrants in the north (i.e., Chiangmai) received higher incomes compared to their counterparts in the south (i.e., Ranong). Fifty-one percent of the Chiangmai participants made more than 3,000 baht per month (Kyat 18,000), compared to 22% of the Ranong participants (Table 4.19).[39]

38 The minimum wage rate in Bangkok is 162 baht per day.

39 The free market exchange rate of 1 baht = 6 kyat, rather than the official rate, is used in this report because it represents the rate most commonly used by the study's participants.

Table 4.19 Percentage Distribution of Participants According to Current Income

Current Income (baht)	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Having own income						
- Yes	71	91	81	95	96	95
- No	29	9	19	6	4	5
Total: Percent	100	100	100	100	100	100
Number	208	206	414	217	190	407
Monthly income*						
1-1,000	7	4	6	3	1	2
1.001-3,000	75	69	72	60	32	47
3,001-5,000	14	20	17	37	66	51
over 5,000	4	7	5	-	1	-
Total: Percent	100	100	100	100	100	100
Number	204	196	400	217	190	407

* household income.

Income differences between and within sites were largely determined by the type of work in which migrants were engaged. In Ranong, workers in rubber plantations earned, on average, a higher income (3,250 baht) compared to those in sawmills (2,800 baht), or fish processing factories (2,700 baht). In Chiangmai, factory workers earned on average over 3,000 baht a month. This was 2.4 times more than construction workers and 1.1 times more than service providers (Tables 4.20 and 4.21).

Table 4.20 Percentage Distribution According to Occupation and Income in Ranong (n=334)

Income	Saw Mill		Plantation		Fish Processing	
	Women	Men	Women	Men	Women	Men
3,000 and less	88%	76%	72%	72%	89%	72%
over 3,000	9%	22%	25%	28%	11%	28%
don't know	3%	2%	3%	0%	0%	0%
Total: Percent	100%	100%	100%	100%	100%	100%
Number	32	55	32	53	83	79

Table 4.21 Percentage Distribution of Participants According to Occupation and Income in Chiangmai (n=382)

	Factory		Constrution		Service	
	Women	Men	Women	Men	Women	Men
3,000 and less	56	15	71	38	53	29
Over 3,000	44	85	29	62	47	71
Total: Percent	100	100	100	100	100	100
Number	39	46	113	105	51	28

As in the larger Thai society, gender inequality with respect to income prevailed among the migrant workforce. Women earned less income than men across all occupations at each of the study sites. Chiangmai participants reported a larger gender income gap than Ranong, with males in Chiangmai to be 5.4 times more likely than females to make over 3,000 baht per month, as compared to Ranong where men made 2.1 times more than women (Figure 4). In Ranong, the income gap between men and women ranged from 3% in plantations to 17% in fish processing factories (Figure 5). In Chiangmai, the percentage differences were greater across all three types of occupations (Figure 6). The largest difference was found in the factories of Chiangmai (41%), where only 44% of women, as compared to 84% of men, received a salary above 3,000 baht. In construction and service sector jobs, gender differences stood at 33% and 24%, respectively.

It should be noted, however, that this study calculated actual gross pay and did not take into consideration additional expenses demanded of migrant workers. These additional expenses were frequently reported during in-depth interviews and focus group discussions among Chiangmai participants. For example, they consistently reported having to pay additional fees for the cost of utilities, housing materials or rent, and bribes to police to ensure they were not arrested. These factors would likely result in considerably less take home earnings than migrants elsewhere in Thailand.

Figure 4 : Proportion of Participants Earning over Baht 3,000

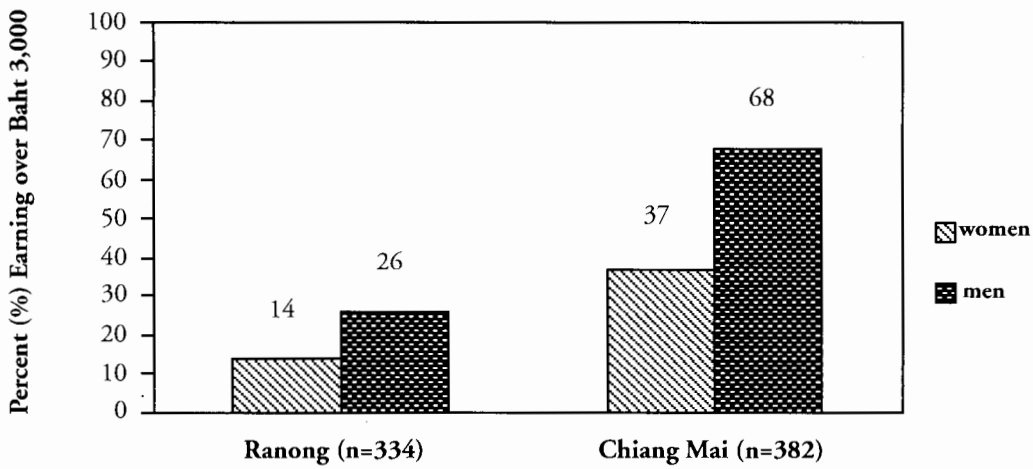


Figure 5 : Income inequality by gender in Ranong
Proportion of Participants Earning over Baht 3,000

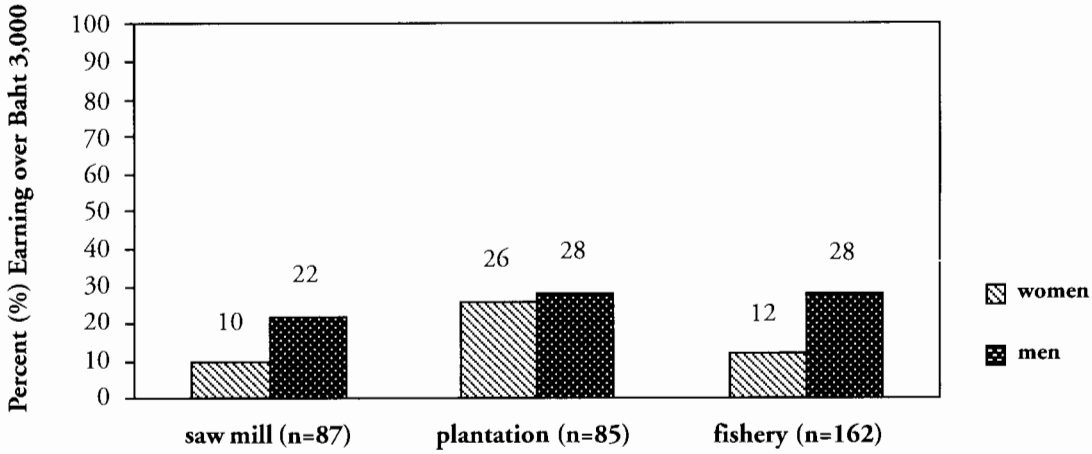
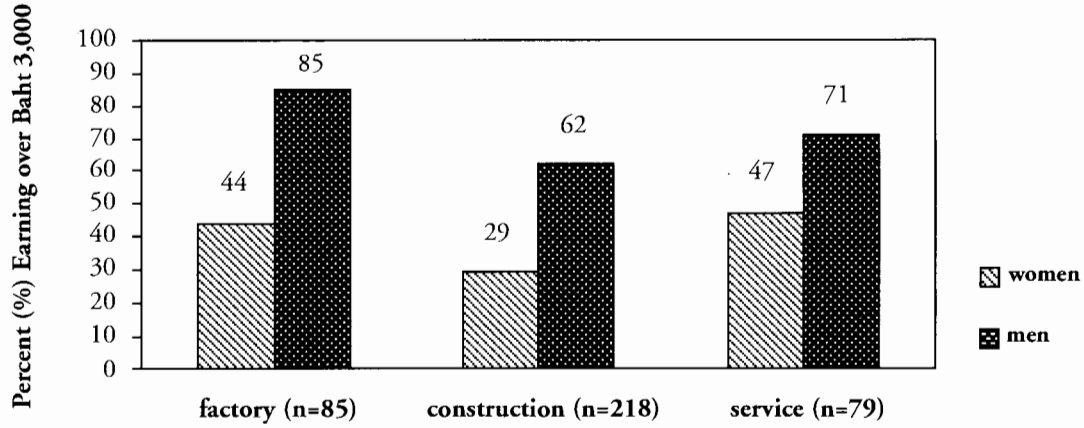


Figure 6 : Income inequality by gender in Chiang Mai
Proportion of Participations Earning over Baht 3,000



4.4.4. Legal Status in Thailand

In examining the legal status of the study's participants, it is important to distinguish the different options available for migrants in Chiangmai and Ranong, and the work permits made available under the legislation enacted in June 1996. Certain Chiangmai participants could apply for various identification cards issued by the Thai government to ethnic minorities residing in the border provinces. Ranong migrants, on the other hand, had an option of obtaining a weekly/monthly immigration permit. Available only at certain border towns, these short-term permits allowed Thai employers to hire foreign nationals for a limited period of time. In addition, employers of migrants in various provinces and industries (including those in this study) could register their employees with the Provincial Employment Office. The Employment Department would provide work permits that registered migrants to live and work for that particular employer.

> *The owner said that he takes responsibility for our security. He said he will take responsibility for the women and extra people who are working here, but will not take responsibility for other people who are not working here. My husband has an ID card, but I don't. Last year we had to pay 3,000 baht just for one ID card. So if we had made two ID cards, we would have had to spend 6,000 baht. The boss said that if my husband has an ID card, I don't need one.*
> Tavoyan woman, age 28, sawmill worker in Ranong

> *We worked on other peoples' farms [near the border] earning 50-60 baht per day. The Township Officer issued us a pink ID card call 'Thaw Raw 13,' but we had to pay 3,000 baht for each card. With this card we can stay in this township, but we cannot go anywhere else. So finding work was hard. The blue color ID card was a little better. We came to Chiangmai to find work with that card. So my husband and I tried to get one each when we were in Chiangmai. We had to pay 8,400 baht for two blue cards. That is how we managed to come to Chiangmai to find work. Once in Chiangmai we had to buy work-permits for both of us and this time we had to give another 2,500 baht each.*
> Shan woman, age 25, construction worker in Chiangmai

> *It has become difficult to work in Thailand now. I do not have a Thai identification card and the employer would only get work permits for the men, not for the women.*
> Shan woman, age 33, construction worker in Chiangmai

> *Those who are working illegally in Thailand must pay 300 baht a month to their employer who then pays the police. This is common on most every construction site in Chiangmai for those with no ID cards.*
> Shan woman, age 28, construction worker in Chiangmai

Sixty percent of the migrants in Ranong held no identification card or permit, as compared to only 30% of the Chiangmai migrants. Gender differences were also apparent. In Ranong a greater proportion of women (70%) than men (50%) had no legal documentation. In Chiangmai, on the

other hand, a lower percentage of women (24%) worked illegally than did men (37%). Access to ID cards was considered by many to provide some protection from arrest and exploitation.

Table 4.22 Percentage Distribution of Participants According to Type of Work Permit

Type of Work Permit	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
None	70	50	60	23	38	30
Work Permit	20	17	19	41	45	42
Colored Card	2	1	1	36	19	28
Border Work Permit	8	31	19	0	0	0
Thai ID Card	0	1	1	0	0	0
Total: Percent	100	100	100	100	100	100
Number	209	206	415	218	191	409

Our employer hates Shan people and is quite mean. He scolds and abuses the Shan workers all the time. We cannot ask help from anyone nor lodge a complaint because we have come to work in another country without legal documents. We don't have any identification cards and do not know anyone.
Shan man, age 29, construction worker in Chiangmai

Living in a foreign country, we are like the blind and mute. We cannot even say what we want to eat, but gulp down everything with our watering mouths and bite our tongues. This is because we do not have identification cards and therefore can ask no one to help us.
Shan man, age 40, construction worker in Chiangmai

There are only three Shan in this area and so we stick to ourselves. After we get home from work we just cook, eat, and go to bed. We are basically healthy and rarely get sick. We feel secure. The police never come here. Our boss is also very kind. He's a police officer himself and his wife is a teacher. We don't have to be afraid of anything where we work.
Shan woman, age 21, construction worker in Chiangmai

The owner will let us work till the end of the month. Then he will replace the Burmese workers with Thai. After much discussion the owner said the Burmese workers could stay on, but he will not take any responsibility for them.
Mon/Karen woman, age 28, fish canning factory worker in Mahachai

Access to an ID card does not necessarily guarantee protection. Migrants were, in some cases, cheated and harassed, arrested or deported regardless of their possession of ID cards. The study's researchers, in one instance, directly observed police arresting migrants in a Shan temple in Chiangmai, even though they had ID cards. This kind of treatment was further corroborated by some of the participants.

> *Police came to the construction site and any one without a Thai identification card ran away. But, we stayed because we had a card. However, the police said that two men on a motorcycle were stopped on the way to town and the driver had no ID card but said he was from the same place as us. So the police arrested all eleven of us even though we were legally working in Thailand. Our employer was also arrested. We were sent to jail for two months and then deported to the border.*
> Shan woman, age 32, construction worker in Chiangmai

Such findings may be skewed, however, since these arrests occurred during the height of the Thai government's crackdown on illegal immigrants. Many migrants without identification cards or permits went further underground making it difficult to reach them and reducing the chances of them participating in this study.

4.4.5. Assimilation

The majority of migrants interacted with Thai society in a restrained and limited manner, due to their illegal status and fear of arrest and deportation. Integration into Thai society was assessed in this study by the ability of migrant workers to converse in Thai and the number of reported Thai friends. The majority of the migrant workers (79%) knew only enough of the Thai language to get by. In Ranong about 25% of both male and female migrants did not know how to speak Thai, compared to only 2% and 4% respectively among the Chiangmai participants (Table 4.23). Although the spoken Shan language is similar to the Northern Thai dialect, only 11% of the Shan participants reported fluency in Thai. The Chiangmai migrants, however, were generally more versed in Thai than the Ranong participants. For example, migrants in Chiangmai were more comfortable shopping and bargaining for food, taking local transportation, and communicating with employers and managers about their work.

Table 4.23 Percentage Distribution of Participants According to Knowledge of the Thai Language

Ability to Speak Thai	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
None	23	26	24	2	5	3
A little*	54	31	43	64	59	62
Well**	19	42	30	19	30	24
Fluent	4	2	3	15	6	11
Total: Percent	100	100	100	100	100	100
Number	210	208	418	218	191	408

* e.g., able to take local transport. ** e.g., able to talk to an employer about work.

Many of the participants did not have any Thai friends (81% in Ranong and 62% in Chiangmai). While having a Thai friend was more common in Chiangmai than in Ranong, there was no gender differences at either site (see Table 4.24).

Table 4.24 Percentage Distribution of Participants Having Thai Friends

Number of Thai Friends	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
No Thai Friends	83	80	81	60	64	62
One or two Thai Friends	12	11	12	24	27	26
Three or more Thai Friends	5	9	7	16	9	12
Total: Percent	100	100	100	100	100	100
Number	207	202	409	181	174	355

The majority of the study's participants remained in their own communities within Thailand. In Ranong, they lived and worked in compounds (for example, sawmills and plantations) and neighborhoods (port area) separated from the Thai population. In Chiangmai, they resided in construction sites, row housing, and dormitories that were set apart, even though some occupations, such as in the markets and other service sector jobs, required interaction with the local population. Even at construction sites and factories in Chiangmai where both Thai nationals and migrants from Burma were employed, housing was separated with Thai workers having considerably better living environments.

The isolation of migrant communities was further exacerbated by cultural differences and limited interaction with the larger Thai society.

The Burmese and Thai do different jobs. The Burmese work to clean the fish and the Thai work with the fish that are already cleaned. The Thais always get the better jobs, salaries, and benefits.
Burmese woman, age 20, shrimp factory worker in Mahachai

We have no rights because this is not our country. If we do something wrong, we will be punished more than others. But, if the Thais do something to us, there is no legal punishment. The people from Burma are often oppressed and abused in the workplace. . . But at least we have a debt and we can pay it off. Some of the Cambodian workers (there are about 50 here) are just like their slaves.
Burmese woman, age 17 year, fish canning factory worker in Mahachai

The Thais are a minority at our workplace so there is no problem. We all receive the same wages. However we enjoy different rights, that's for sure.
Burmese man, age 20, laborer for a shrimp transportation company

4.5 Concluding Remarks

This chapter has sketched a profile of the participants involved in this study, all of whom were migrants from Burma residing in the Thai provinces of Chiangmai, Ranong, and Mahachai at the time this study was conducted. They worked primarily in construction, factories, plantations, sawmills, fish processing plants, and the service sector. In Chiangmai, the participants were predominantly Shan (96%), with other ethnic populations making up the remaining four percent. The majority of participants in Ranong were Burmese of Tavoyan descent (84%), and also included the Mon (12%) and Karen and Arakanese (4%) ethnic groups. The ethnic composition of participants in Mahachai was similar to those in Ranong.

Almost all of the participants were Buddhist (97%). Their age range across all three sites was 15-50 years old, with the mean age of participants being 27.5 years. Attainment of formal education was significantly higher among Ranong participants than those in Chiangmai. Twenty-eight percent of all participants had never been married and only 78% of those married reported currently living with their spouse. The majority of those married were wed before the age of 20. The average number of children among couples in Chiangmai was 1.9, as compared to 2.9 children among the Ranong participants and an overall fertility rate of 3.5 in Burma (Human Development Report, 1998).

On average, the participants had arrived in Thailand for the first time three and a half years prior to being interviewed for this study. The majority had held land and employment prior to leaving Burma. All of the participants noted harsh economic conditions and lack of security due to political conditions, as reasons for their migration to Thailand. In noting the interconnectedness of political and economic factors the migrants did not distinguish between

labels of 'refugee,' 'displaced person,' or 'economic migrant.'

Migration from Burma to Thailand often entailed the use of agents, brokers, or individuals who were familiar with routes of travel, border check points and/or employment networks. In addition, Mahachai participants, in particular, reported relying on agents to find them jobs once in Thailand, while those at other sites relied more on informal social networks. Once in Thailand, the majority of the study's participants did not return to Burma and did not maintain contact with their family back home. The participants largely resided in only one province and had not migrated elsewhere in Thailand. However, Chiangmai participants had relocated frequently within the province compared to those in Ranong. All participants reported rarely leaving their place of residence and/or work for fear of arrest, with women perceived as being at greater risk.

Migrants rarely switched between occupations once in Thailand, averaging less than two different jobs each. Marital status and gender were major factors in determining the type of work available and salary received. Unmarried women worked largely in factories and as domestic servants, while unmarried men commonly worked on fishing boats. Women consistently received lower salaries than men, even in similar occupations.

Sixty percent of the migrants in Ranong held no identification card or permit compared to only 30% in Chiangmai. Access to ID cards offered some (but did not guarantee) protection from arrest and exploitation. Men in the study were most likely to be registered by their employers with the Thai Department of Employment for official work permits. Yet, there were also cases of migrants being cheated and harassed, arrested, or deported, regardless of their possession of ID cards. Integration into Thai society was greatly limited by the migrants' tenuous or illegal status. The majority reported feeling isolated in their own communities and did not mix with Thai people.

The Burmese soldiers would come to the village and force men and women to carry their ammunitions that were very heavy. They would beat any one who was slow and could not keep up. They treated women very badly and in the night they would rape us. They caught seven women from our village. They raped them all and one girl they kept for three days. Two of my nieces were among them. After that I left with my nieces and others from my village.
(Shan woman, age 22, construction worker in Chiangmai)

I tried to help some people out of the police station. I went there and paid 13,000 baht for the release of two people. The people there asked me to help two women, a mother and a daughter whom the police and senior prisoners were raping all the time. The daughter was about 17 or 18 years old and very beautiful. Before I could help, they both hung themselves. People said there were four other girls in police custody in a similar situation. It happens everyday.
(Mon man, age 23, laborer in Mahachai)

Chapter 5
Violence and Abuse

The migrants who participated in this study reported numerous accounts of violence both in Burma and Thailand, and within their household and community. Incidences of abuse in Burma were repeatedly brought up in the interviews and were cited as a primarily reason for seeking refuge and security in Thailand. A considerable number of migrants also noted violence and abuse incurred by agents and officials at their work place and living quarters in Thailand. Domestic and community violence was also mentioned frequently, with incidents occurring both in Burma and Thailand. These experiences of violence will be discussed according to where they occurred and the type of abuse encountered.

5.1. State Violence in Burma

Participants at all three sites reported accounts of war, forced relocations, conscription of laborers and porters, rape, taxation, and/or harassment in Burma. However, Chiangmai migrants from Burma's Shan State reported more frequent and more blatant abuses. While political violence was less common in the South, the Burmese military policies of heavy fines and taxes, as well as coercion, was reported to have disrupted the lives of many participants and threatened their economic survival. The participants at all three sites identified the root cause of their economic and financial difficulties as being political in nature.

5.1.1 War and/or Political Repression

As noted earlier, the Myanmar government has maintained tight control over the country since 1962, imposing harsh crackdowns on any political discourse. In addition, the government has attempted to "mainstream" the diverse ethnic groups throughout the country, which has

resulted in ethnic strife for decades. These realities have led to a massive dislocation of dissidents and minorities within the country and across neighboring borders.

My husband was an assistant headman in our village and he also served in the Peoples' militia. He had to be afraid of different groups. He had to collect rice and money when the insurgents asked for it and if the Burmese soldiers suspected him they would punish us. Sometime in the summer of last year, the people of our village were beaten and forced to move to another town by Burmese soldiers. It happened because the insurgents borrowed the large cooking pots from the temple and the monks could do nothing but lend it to them. Then the Burmese soldiers attacked and overran their base. They found the cover of a large cooking pan with our village's initials on it. They came and beat the villagers and took all the money and gold that was kept with the Abbott at the temple. They even beat the Abbott and forced him to disrobe. They forced everyone to leave in the night.
Shan woman, age 33, construction worker in Chiangmai

The worst thing for me is that the Burmese soldiers killed both my parents. You can just imagine how I feel. Burmese soldiers often forced us to be porters. They provided us little food while we worked as porters, and when we were sick on the way and could not walk they hit us with the butt of their guns. ... Fighting often broke out around our village. The Burmese soldiers would take this opportunity to enter our village. They would leave nothing. They would shoot cows, buffaloes, chickens, everything. They would beat men and rape women. That is why we all fled to Thailand, men and women. If the Burmese soldiers kill our buffaloes and cows, we cannot cultivate our crops.
Shan woman, age 27, construction worker in Chiangmai

There were three brothers in my family and one was conscripted by Khun Sa to be a soldier in the Shan army. Not long after he was conscripted, the Burmese soldiers got news about it and in the early hours before dawn (when the cocks had only crowed twice) the Burmese troops surrounded and ransacked our home, taking whatever they wanted and burning it to ashes. They tied my farther and mother with a long rope and forced them to walk along the streets and up and down through the villages while they shouted accusations "These are two rebels, opium traffickers of Khun Sa, robbers." Then, they locked them up in a military base for ten days and interrogated them. My eldest brother tried to sell our rice fields to bail them out. When it was clear that we could not help my parents and that the soldiers were going to conscript my brother and I into Burmese military, I willingly joined the rebel soldiers. However, after one year, Khun Sa surrendered. So, I decided to come to find work in Thailand, as I am sure that I cannot return to my village. I do not know if my family is dead or alive. I came to Thailand to earn enough money to go and look for them. If they are no longer in this world I will join the soldiers of the resistance and seek revenge.
Shan man, age 24, construction worker in Chiangmai

The Burmese military stationed near my village said they had a report that I was working with the opposition groups. I was imprisoned and tortured by them for two years. In the end, they had no evidence that I was guilty and released me. I did not dare to return home so I took my family to Thailand.
Shan man, age 30, construction worker in Chiangmai

I did not intend to come to Thailand to work. I left Burma after the 1988 uprising to come to the border with all the students. I was in tenth standard at the time. I had been at the border for one and a half years when one person from our group surrendered and everyone in our group was arrested when we crossed the border. I was sentenced to three years in prison. After three years I was released, but had no rights to attend school or find a job easily. It was impossible to stay under those circumstances, so I returned to Thailand.
Mon man, age 23, laborer in Mahachai

5.1.2 Forced Relocation

As many human rights organizations have documented, the Shan people in recent years have experienced escalating abuses at the hands of the Burmese military (Amnesty International, 1998, Shan Human Rights Foundation, 1997). Almost half of the Chiangmai participants (47%) had been forced to leave their homes and relocate to areas designated by the military regime compared to 16% of the Ranong participants (Table 5.1).

Table 5.1: Percentage of Participants who Experienced Forced Labor and Relocation in Burma

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Forced as Porter	30%	19%	25%	51%	68%	59%
Force Labor	75%	60%	67%	77%	83%	80%
Forced Relocation	18%	15%	16%	44%	51%	47%
Total Number	210	208	418	218	191	409

The following are stories of how migrants from Shan State were forced to relocate from their villages.

My family members were all farmers and life in Shan State was good. Then the Burmese soldiers forced us to move to a city. We had only three days to move all our property. We could not move all our things and livestock in that time and so the Burmese shot and ate our chickens, pigs, and cattle. My family moved to the city but could not survive. So, after nearly four months we came to Thailand to earn a living.
Shan man, age 29, construction worker in Chiangmai

I did farm work when I was in Shan State. I grew corn in my village. Later on, I couldn't continue my work on the farm because the soldiers would not let us stay in our village. They told us to move into towns. We couldn't even go fishing at night because they would shoot us. Then I heard that the soldiers were recruiting men for the army. I was afraid that my sons would be drafted, so my family all decided to come to Thailand.
Shan woman, age 25, construction worker in Chiangmai

When we lived in Kae-See, the situation was chaotic. Because fighting often took place in the areas near our villages, the Burmese troops forced our villages to move together into the town. Anything that had not been moved within the given time, such as pigs, chickens, and cattle were shot, and those who had farms and fields had no time to do anything. Our village was burned down by Burmese troops and the villagers moved to the town, some sought help from their relatives and some came to Thailand.
Shan man, age 29, construction worker in Chiangmai

At home we work on our own farm, growing soya bean, groundnut, and some vegetables. The main crop is paddy. In doing this it is enough to feed every one in the family. But fighting often broke out between the Burmese army and rebel troops. The Burmese will take this kind of opportunity and come and loot our property; sometimes they burn down our houses. We have the Burmese army as well as the rebel army, so there is nothing left for ourselves. Life is hard at home. That is why we come to Thailand.
Shan woman, age 24, construction worker in Chiangmai

5.1.3 Conscription of Porters, Soldiers, and Laborers

The number of those who experienced forced conscription as porters, soldiers, or laborers was significantly different between the Chiangmai and Ranong sites. As Table 5.1 illustrates, one quarter of the Ranong participants were forcibly conscripted as porters by the Burmese military, whereas more than twice that number of Chiangmai participants (60%) had endured forced conscription. Chiangmai participants were also more likely than their Ranong counterparts to be conscripted as forced labor on government projects, which included no remuneration or compensation for loss of income. The proportion of those conscripted as forced labor, however, was high at both sites: 67% in Ranong and 80% in Chiangmai. The significantly higher percentage of Chiangmai participants who experienced forced conscription reflects conditions inside Burma. The Chiangmai participants are predominately of the Shan ethnic group, which is known to bear the brunt of the military's forced conscription practices.

In our country, we were often forced by Burmese soldiers to carry their things up hills and mountains to fight the insurgents. They also force us to do many other things, like fetching bath water and building fences around military camps. They would even force us to give them pigs and chickens to eat with their whiskey, and many other things. On the other hand, the insurgents forced the villagers to join the rank and file of their armies, and I was so afraid of having to serve in the insurgency that I decided to join the Buddhist monk order and came

to Thailand wearing the yellow robe.
Shan man, age 25, construction worker in Chiangmai

I am a farmer. Back at home we have a tea plantation. We also have places to grow rice. Since it is on the mountains we have to practice dry agriculture. The weather is kind all year round and we have plenty to eat. If it were not for the brutality of the Burmese soldiers, we wouldn't be here working so hard and getting very little. When the Burmese soldiers came to our village they took whatever they wanted, they took away our livestock. They took our paddy in the barn to feed their horses. All the men would flee the village at the news of Burmese soldiers because they always forced men as porters. Sometimes women too are taken as porters and they rape these women often. We are not able to do our own work, since we have to work for them in one or other way. We have to construct roads for them and they ask us to cut bamboo to construct their barracks. The Burmese never leave us alone. They always threaten our lives and that is why we came here to Thailand with the intention of finding good jobs so we can save money for our future.
Shan woman, age 22, construction worker in Chiangmai

If a road is to be constructed, there's no way to avoid going along (with the road construction gang) to work. If you don't, there's a fine of 200 or 100 kyat. It's not every day that we are required to work. There are times when you have to go four or five days a month. They would threaten us. Because of my children, I had to hire a person to go in my place with the road construction gang and that costs about 3,000, 4,000, 5,000 or 7,000 kyat. We had to hire someone like that. If my husband wasn't home, I'd have to sell my gold jewelry, or rice to hire someone to take my place. Our income is just not enough to meet all these costs.
Tavoyan woman, age 25, sawmill worker in Ranong

I often had to go and serve as a porter for the Burmese soldiers and had to build military camps, roads, bridges, and railroads so often that I virtually had no time to care for my own needs. When I was hurt or not feeling well, I had to help myself. It was like living hell. It was like being dead even though we were alive. So I sold all my household belongings and managed to get enough money to cover my travelling costs and asked my friend who had worked in Thailand who was visiting his parents to let me come with him.
Shan man, age 34, construction worker in Chiangmai

We were not able to meet our daily needs and moreover we were conscripted into railway construction sites without payment. If we did not want go to this construction site, we had to pay 200 kyat a day. But our daily earning is about 100 kyat. So, we were not able to solve these problems. We faced all these kinds of problems living in Burma.
Tavoyan woman, age 25, sawmill worker in Ranong

5.1.4 Rape

For some of the Chiangmai participants, the fear of rape and arrest by military or government personnel characterized their life in Shan State and was a critical factor in their decision to migrate to Thailand.

> *The Burmese soldiers seized our village and property, accusing the villagers of not informing them about the rebels. The soldiers raped a single girl in our village who was about 17 years old. That is why women in Shan State marry so young as the Burmese soldiers usually rape the single women. Many people from our village decided then to go to Thailand. On our way to the border two other girls were taken by the Burmese soldiers, one was eleven and the other nineteen. The younger one managed to run away, but they kept the older one all night and the next day we had to go on without her.*
> Shan woman, age 32, construction worker in Chiangmai

> *My 16-year old niece was raped by the Burmese troops while collecting vegetables. We lodged a complaint but the Burmese authorities took no action. The men were often forced to serve as unpaid porters under difficult conditions. We were treated like pigs and dogs and had no right to complain or protest anything. So we came to Thailand. My entire extended family came.*
> Shan man, age 40, construction worker in Chiangmai

> *The Burmese soldiers would come to the village and force men and women to carry their ammunitions that were very heavy. They would beat any one who was slow and could not keep up. They treated women very badly and in the night they would rape us. They caught seven women from our village. They raped them all and one girl they kept for three days. Two of my nieces were among them. After that even I left with my nieces and others from my village.*
> Shan woman, age 22, construction worker in Chiangmai

5.1.5 Taxation and Confiscation by the State

Arbitrary taxation and fixed prices for food, often considerably lower than the market value, forced many people into poverty and into considering migration to Thailand, as did the arbitrary confiscation of property by government personnel.

> *We had a business buying merchandise from Thailand and selling it in Myanmar. One time the Burmese authorities said that these items were bought on the black market and confiscated them. We lost a lot of money. Before that we traded horses and over twenty of them were confiscated by the authorities. This happened so many times. We once had 32 cows that were also seized by the authorities. Whatever business we did we lost our money because of problems with the authorities. So, our entire family decided to come to Thailand.*
> Shan woman, age 45, old construction worker in Chiangmai

> *I traded cattle and sold them to villages along the Shan State border. I also bought goods to trade as well. Bandits robbed me and the Burmese soldiers took all my cattle. I lost all my*

capital and went bankrupt. So, my whole family came to work in Thailand.
Shan woman, age 22, construction worker in Chiangmai

My family members were all farmers. Some years we could earn enough, but in other years we could not and went into debt. We had to give our rice to several rebel groups and the Burmese collected too much and too many taxes. The Burmese soldiers always forced us to do many things such as building military camps, fixing roads, and being porters for their armies without anything in return. We did not have enough time to do our own work. That was why we decided to come to Thailand.
Shan man, age 40, construction worker in Chiangmai

At home it was so difficult to earn money and things were made worse by higher and higher taxes. We couldn't afford it. In our village we always had to be paying taxes.
Tavoyan woman, age 29, turtle farm worker in Ranong

When I return home they will take note of it and they will calculate my land tax. At the moment the tax is low about 700 kyat a month, but next month it could be 2,000 kyat. It is like this. They'll add it up 700, 2,000, 500 and 90. When I return, and my fees are determined to be say 15,000 kyat, I will have to pay it all in full. How can I live like this?
Tavoyan woman, age 28, farm worker in Ranong

These abuses of basic rights were the pre-dominant reason given for leaving Burma and remaining in Thailand, even though it was difficult for the migrants to sustain a livelihood in Thailand.

5.2. Violence in Thailand

5.2.1 Abuses Encountered as Illegal Migrants

Arrest, detention, and deportation or fear of these was of utmost concern to the migrants. Thai police had arrested thirty-eight percent of the study's participants, as shown in Table 5.2. In the year prior to this study, Chiangmai participants were arrested, on average, 1.3 times. This was almost twice as high as their Ranong counterparts (0.7).

Table 5.2: Percentage of Participants Arrested by Thai Police or Soldiers

Arrests	Ranong			Chiangmai			Both Places		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Percentage Arrested	23%	39%	31%	30%	62%	45%	27%	50%	38%
Mean No. of Times Arrested*	0.8	0.6	0.7	1.0	1.6	1.3	0.9	1.2	1.1
Number	208	205	413	215	189	404	423	394	817

* In the year prior to participating in the study.

Not all of the participants who were arrested were detained, since Thai police often release migrants after extorting an arbitrary sum of money. Those who were detained reported enduring abuse at the detention center, with young women, in particular, reporting incidents of sexual abuse.

I tried to help some people out of the police station. I went there and paid 13,000 baht for the release of two people. The people there asked me to help two women, a mother and a daughter whom the police and senior prisoners were raping all the time. The daughter was about 17 or 18 years old and very beautiful. Before I could help, they both hung themselves. People said there were four other girls in police custody in a similar situation. It happens everyday.
Mon man, age 23, laborer in Mahachai

One morning before daybreak police raided our work place and fifteen of us were arrested. If I could have paid 2,200 baht I would have been released. But, I did not have the money so I was imprisoned. I stayed in prison for nearly three months and was deported to the border area in Tak Province. The prison where I stayed was mostly full of Shan and Burmese. The conditions there were miserable. There was not enough food and each person only received seven bowls of water per day. There were no beds, blankets, or mosquito nets. It was terribly overcrowded and everyone had to sleep, eat, and urinate in the same room. It was common for inmates to rob others in front of everyone. There was a kind of organized gang, which no one could do anything about it. If anyone protested, they would be beaten and kicked. I lost a set of clothes and one watch and was beaten several times. I also saw several pretty women called out by some police officers. They were taken away for several days and some never returned. The police said they were taken to do domestic chores. After I came out of prison I was weak and did not want to do anything. Gradually I recovered and returned to Chiangmai to work again.
Shan man, age 24, construction worker in Chiangmai

After working six months, my wife and I managed to save some money. I traveled to the border to send it back to Shan State for my children's education. But as soon as I got down from the bus a policeman asked for my identification card. He searched my entire body and took away 6,500 baht. He left me with only 500 baht. I could do nothing so I went back to my wife and now we have to try to save again.
Shan man, age 48, construction worker in Chiangmai

I wanted to go back to Shan State to find my parents. Near the border a policeman came onto the bus and called me down. He searched me and saw my tattoos. I said I was Shan. He found my wallet, opened it and found 13,000 baht. He took 10,000 and told me I could go back on the bus. I had only 3,000 baht left so I just returned to the construction site in Chiangmai to continue working.
Shan man, age 21, construction worker in Chiangmai

The police arrested me twice. The first time I was sent to the IDC[40] and then the Kanchanaburi police station. From there I was deported to the border. When I tried to come back to Thailand I was seriously injured in my face. We were all walking at night along the jungle route without any light. The girls in front of me were hit by a branch and thought it was a gun. They screamed and turned to run away and everyone fell. Finally we got back to Thailand where I agreed to repay an agent 5,000 baht to bring me back to Mahachai again. Then after being back just five days I was arrested again. This time my employer paid 1,000 baht for me to be released and I will have to add it to the money I already owe.
Burmese woman, age 30, shrimp factory worker in Mahachai

At the pineapple factory only women were allowed to work. There were 22 women altogether. One day the police raided the factory and 18 women were arrested. I was so lucky to escape. The employer was able to negotiate their release after a few days, but now they all owe him money but they were never told how much.
Burmese woman, age 20, shrimp factory worker in Mahachai

I needed to buy medicine for my wife so I went to town. On the way back from buying the medicine I was arrested. The police asked for my work permit and I tried to explain I did not have one and was just going to buy medicine for my sick wife. I gave him 700 baht, which was all I had. He asked me to pay 5,000 baht. I told him I didn't have that kind of money. He then asked me to find someone to borrow it from. I said I would do so and then ran away.
Burmese man, age 30, factory worker in Mahachai

The police in Mahachai arrested me. They took all I had and did the same to four other migrants from Burma. They took everything, rings, necklaces, and money. Then they said in Thai "go back." Those who didn't have anything had to wait for their employer to come and pay 2,000 baht for their release.
Burmese man, age 22, shrimp factory worker in Mahachai

The Asian financial crisis hit Thailand in the latter half of 1997 and pressured by a weakened economy, politicians and policy makers were quick to direct their frustrations toward the one million foreign migrants in Thailand. By January of 1998, massive crackdowns at factories and construction sites began and included widespread arrests and deportation of illegal workers.

In the beginning it was quite free, I didn't have to worry. Right now, there is no freedom. There are many police. I am thinking about running away. I can't sleep. I am constantly thinking about how to escape the police. One time I ran to Kawthaung and also into the woods in Burma. People say they (the police) are coming, but they have not actually come to

40 Immigration Detention Center in Bangkok.

arrest yet. The employer tells the people here that if they just stay behind closed doors and in their own rooms, he will be responsible for them. He says not to run around. But I will not stay. I will just run away. Others will run away too.
Tavoyan woman, age 29, sawmill worker in Ranong

The Thai government has launched a crackdown on illegal migrant workers to send us back to our country. They will check this month [March 1998] in nine kinds of factory businesses. If the employer has any migrants working, he will be sentenced to three years in prison and fined 60,000 baht. So, now we are facing a real problem.
Male participant in a focus group discussion held in Mahachai

I had worked just 15 days when the police came. My wife and I ran and climbed a wall and jumped into the mud. I was able to run away, but broken glass in the mud hurt my wife, so she was arrested with ten others. After being sent to many detention jails she was finally deported to the border many months later. We found a job near the border but were cheated out of our money so many times. We couldn't stand it any more and returned to Mahachai. Now, we face the same situation again of fearing arrest.
Burmese man, age 30, factory worker in Mahachai

Now as the Thai economy is dwindling, Thai authorities are chasing us again. We don't know what to do. We don't know what our fate will be. We just have to wait and see.
Shan woman, age 24, construction worker in Chiangmai

5.2.2 Economic Violence and Abuse

Thirty-eight percent of the participants experienced having pay withheld by their employer, or not being paid at all, or being paid less than the amount promised (Table 5.3). However, the proportion of migrants who were cheated wages was significantly different between those working in Ranong (25%) and those in Chiangmai (53%). Although, the majority of this abuse was from employers (over 90% at both sites), state officials, intimate partners, and family members were among others involved in such violations. Thirty-three migrants, or approximately 4% of all study participants, reported being held in debt-bondage by their employer and forced to work off a debt without clear terms of repayment (to be referred to in this report as trafficking). Trafficking networks were very different between the two sites. In Chiangmai, the traffickers were predominately the migrant's employers (76%), whereas in Ranong they were more likely to be the migrants' close friends (45%). Previous studies have also found that trafficking networks often involve individuals whom migrants trust and have close relationships (Archavanitkul 1998; Archavanitkul and Koetsawang 1997).

Table 5.3: Percentage of Participants who Experienced Economic Violence and Abuse

Econnmic Violence and Abuse	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
% not paid for work	25%	25%	25%	39%	68%	53%
(N)	(51)	(50)	(101)	(84)	(129)	(213)
% abused by employer	84%	98%	91%	91%	98%	95%
% trafficked	2%	3%	3%	8%	2%	5%
(N)	(5)	(6)	(11)	(18)	(3)	(21)
% trafficked by employer	0%	0%	0%	77%	67%	76%
%trafficked by close friends	40%	50%	45%	11%	0%	9%
Number	208	203	411	216	189	404

Migrant workers had wide-ranging experiences with their Thai employers. As is to be expected, the study's participants interacted with a diverse array of employers. While cases of abuse and coercion certainly existed, there were also employers who took responsibility for the safety and health of their workers. The in-depth interviews revealed, however, that in cases of abuse and coercion the migrants had no way to seek redress and could only remedy the situation by leaving.

The boss and his wife were kind, but the wife's brother use to visit them when the university was closed. He always tried to harass me physically. He pretended that he was just kidding by touching my private parts. I was afraid of him so I asked the Burmese caretaker to marry me. He agreed so now there is no problem.
Mon woman, age 22, farm worker in Ranong

We worked for six months without receiving our pay. One day we finally asked for our pay. The employers told us if we wanted their money, we would have to take their guns as well. We were so frightened we ran away.
Tavoyan man, age 18, farm worker in Ranong

My mother was arrested while working in Mahachai. She was sent to the border at Kanchanaburi. There she was sold to an employer for a debt of 12,000 baht and sent back to Mahachai. Afterwards she ran away. When I finally found her, her feet were full of thorns and her clothes was torn. If she is caught she will be killed. Now we are in real trouble.
Burmese man, age 30, factory worker in Mahachai

I was employed on a shrimp boat. The owner insisted we fish in Burmese territory. After seven months, the Burmese army detained the boat. I was arrested and sentenced to three and a half years in prison. I served one year in Mait prison and another year in Insein. I was released

early and returned to Kawtaung because that is the address I gave them when I was arrested.
Arakan man, age 36, cashew nut farm worker in Ranong

The boss and his wife wanted to adopt our baby. They tried many ways to get the child. Their last attempt was to offer to buy the child from us, but we refused. Fearing that they would eventually take our child, we ran away.
Shan woman, age 25, construction worker in Chiangmai

I found some people who had been sold and were held for a ransom of 4,500 baht each. I had no money but I borrowed from some friends and they gave me 9,000 baht, so we could rescue two people. But one young girl was taken as the kidnapper's wife and I was not in time to rescue the other three.
Mon man, age 23, laborer in Mahachai

Migrants had no means to address such abuses, the only option being to quit and seek employment elsewhere. As the financial crisis unfolded, job opportunities were limited, which resulted in fewer options for migrants to deal with these abuses.

5.3. Sexual Violence and Other Community Abuses

5.3.1 Forced Marriages

A small number of migrants (30 cases or 4% of the survey participants) were forced to marry prior to or shortly after migrating to Thailand (Table 5.4). Despite this small sample, the findings clearly indicate that a significantly higher proportion of women than men was forced to marry (27:3). The female participants in Chiangmai were more likely to experience forced marriages in Thailand, whereas their counterparts in Ranong were more likely to have been forced to marry in Burma or on route to Thailand. In Chiangmai, their own family members forced 44% of the women into marriage. In contrast, 56% of the women in Ranong were forced by their intimate partners into marriage.

Table 5.4: Percentage of Participants Forced to Marry

Forced Marriages	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
% forced to marry	8%	1%	5%	4%	1%	3%
(Number)	(207)	(205)	(412)	(216)	(190)	(406)
% forced by intimate partner	56%	0%	47%	22%	50%	27%
% forced by family member	18%	100%	26%	44%	50%	27%
% in Burma or along route to Thailand	69%	67%	68%	30%	100%	33%
% in Thailand	31%	33%	32%	70%	0%	77%
(Number)	(16)	(3)	(19)	(9)	(2)	(11)

According to the in-depth interviews, a considerable number of women migrants reported that they married for safety purposes once in Thailand, since single women were considered vulnerable to discrimination and violence.

My employer married me to one of his workers saying 'it was not decent for a mature woman to be single.'
Shan woman, age 25, construction worker in Chiangmai

People have narrow minds on girls who come back from Thailand, especially those who are not married. They assume they are prostitutes. That is why I got married.
Shan woman, age 18, construction worker in Chiangmai

When I arrived in Thailand I had to take a husband just to keep safe from danger.
Mon woman, age 22, farm worker in Ranong

I'm scared to live at this construction site without a man around. I'm scared of being bullied by others. Here, if people know that there's no man in the house, they take advantage and come and go as they wish. I didn't want others to think lowly of us. That's why I got married to another man.
Shan woman, age 33, construction worker in Chiangmai

5.3.2 Domestic Violence

Many migrants reported high rates of domestic violence in Thailand and felt there was not a strong enough sense of community or outside support to intervene.

My husband used to visit other women and when he was drunk he used to beat and kick me. It is good that he now went away and married another woman and I am rid of him. He was just a burden.
Shan woman, age 36, construction worker in Chiangmai

My first husband took both alcohol and opium and so I left him. After I had a child for seven or eight months I married another man. He was a gambler and a bully. He was good at the beginning, but after five or six months he started to show his real colors. He was very unpredictable when he was drunk, anything could happen. After a while we had a violent row and my husband beat me until I lost consciousness. He also visits prostitutes and I am afraid of HIV/AIDS, but he doesn't care. I am so upset whenever I think about it that I forget what I am doing. I am sick at heart and mentally disturbed because I have long been put down and bullied by him. Now we have a child together and I do not know what to do.
Shan woman, age 25, construction worker in Chiangmai

My husband always shouts and throws things at me in Thailand. Last night, we divided our savings and each took 3,700 baht and one baht of gold and separated. Now, I have to figure out what to do.
Shan woman, age 25, unemployed in Chiangmai

My husband would come home drunk and fight with me. He would yell at me and scold me for everything. He would pull my hair and beat me. He bullied me a lot. We had a small child so I tried to stay together. I was crying most of the time. One day he brought home one of his other women and I couldn't take it anymore. So I divorced him and moved to another place with my child.
Shan woman, age 20, construction worker in Chiangmai

I have one bad habit, sometimes when I go out to drink with my friends I get lustful for sex. I would try to have sex with my wife and she would complain. I would slap her once or twice and sometimes say I would go and find another woman or go to the brothel. Then she would become reasonable again. Sometimes she is quite pitiable. I will try to quit that bad habit in the future and work hard.
Shan man, age 25, construction worker in Chiangmai

Since we married, we have quarreled several times. Mostly because she doesn't want me to drink and smoke. I beat and kicked her once and after that she is not so quarrelsome any more.
Shan man, age 21, construction worker in Chiangmai

My father says we are lazy to work. He curses me and always kicks me. I often feel sad and cry. My father is very rude. One of my sisters ran away and got married. Another sister has been severely beaten because my father found a love letter of hers.
Shan woman, age 17, construction worker in Chiangmai

When my husband gets drunk he accuses me of loving some other men and betraying him. He says I am not a good woman. I suffer so much. If I open my mouth my husband will beat me. I live in fear.
Tavoyan woman, age 28, sawmill worker in Ranong

My children and husband are all individuals with their own flaws. When there is drunkenness there will be beating. That's marriage.
Tavoyan woman, age 28, turtle farm worker in Ranong

My mother died when her second husband came home drunk and beat her with an umbrella. She was sent to the hospital and died seven days later.
Tavoyan woman, age 28, sawmill worker in Ranong

5.3.3 Other Forms of Violence

Migrants also reported other forms of violence in their community that directly impacted their safety and security. Approximately one-third of all the migrants who were surveyed experienced having their things stolen or confiscated, or being robbed or cheated within their community (Table 5.5). Most migrants in Chiangmai claimed that their employers were the persons most responsible for these violations, whereas migrants in Ranong said it was their intimate partners who were committing the violations.

Table 5.5: Percentage Distribution of Participants who had Personal Items Stolen or Confiscated or were Robbed or Cheated According to Perpetrator

Perpetrator	Ranong	Chiangmai	Both Sites
Family member	4	1	3
Intimate partner	59	9	34
Other*	37	91	63
Total: Percent	100	100	100
Number	144	137	281
% experienced items stolen	35%	34%	34%

* Including employers, state officials, and friends.

Discussions held during the in-depth interviews, provide graphic accounts of the violence migrants encountered in their community.

One Shan woman promised to provide work permits and many people paid her 10,000 baht in advance. Then she ran away with the money. Not long after that, she was killed and her body was cut into many pieces it was said.
Shan woman, age 21, construction worker in Chiangmai

One Shan man needed money to support his drug habit. He robbed a construction worker and took two ounces of gold and about 2,500 baht and beat him in the head. The he came again with a gun and robbed another family of three. The family wouldn't give him any money and so he shot and killed them all. The construction workers planned to beat him up when he came again. When he returned the workers beat him until he was dead. The police didn't do anything about it because they were all Shan and didn't involve any Thai people.
Shan woman, age 32, construction worker in Chiangmai

There was a fight here and many people were shouting at a Mon man, but they did not kill him. Later they caught him and stabbed him to death. There is nothing anyone can do about it.
Mon woman, age 15, factory worker in Mahachai

There is a gang from Burma that controls this area. One night they killed a man from Yangon at this work site. The man was tied up and killed. The boss didn't take any action because that group is too strong. He didn't prosecute anyone.
Burmese man, age 22, factory worker in Mahachai

There is a mafia here and they are involved in selling drugs. Many people go missing here and no one can do anything about it.
Burmese woman, age 20, plywood factory worker in Mahachai

The agent who brought me here claimed I didn't pay back all my debt and he came to threaten me. He squeezed my neck and told me that it is easy to kill someone in Thailand. I am so scared to be killed because there are many murder cases here.
Burmese woman, age 20, shrimp factory worker in Mahachai

The robbers dressed as policemen and raided our women's dormitory. They had guns and the entire police uniform on. They took over 30,000 baht in cash and 5K of gold.
Female participant in a focus group discussion held among factory workers in Mahachai
About nine months ago three Thais, acting like police officers, pointed their guns at my chest and asked for money. They said if I didn't give them money they would shoot me. The others were quite far away so I couldn't ask for help. They took away all the money I had saved, about 4,000 baht. In the morning I told my boss but he said not to worry.
Burmese man, age 22, factory worker in Mahachai

5.4 Concluding Remarks

The migrants participating in this study reported numerous accounts of violence both in Burma and Thailand, as well as within their communities and households. Accounts of war and political repression, forced relocations, conscription of laborers and porters, rape, taxation and/or harassment in Burma were frequently reported. Participants in Chiangmai reported more frequent occurrences of the above noted abuses. Migrants in Mahachai and Ranong reported indirect violence, such as heavy fines and taxes, and coercion and economic policies that

undermined their survival. Some participants reported accounts of political repression that resulted in psychological and physical violence. These abuses were the predominant reason given for migrating, even though economically it was difficult to sustain a livelihood in Thailand.

Participants consistently reported encountering abuses Thailand, primarily as a result of their illegal status. Nearly half of all the participants (45%) had been arrested at least once by Thai police or soldiers, who often extorted money from them for their release or detained and deported them to the border. Arrests escalated during the time this study was conducted as a result of massive crackdowns ordered in response to the financial crisis. Over one-third of the migrants (38%) reported being cheated or abused by their employers or at the workplace, with no recourse to remedy except to quit and seek a new job. The financial crisis reduced job opportunities, leaving migrants with fewer or no options to deal with these abuses.

As a result of violence and abuse in both Burma and Thailand, women often married for protection, especially since single girls and women were considered as more vulnerable to discrimination and violence. Both men and women reported many incidents of violence in their community, as well as their home, including the economic violence of employers who refused to pay wages, domestic violence, violence by agents and officials, drug-related and gang-related violence, etc. Migrants live under constant fear and frustration. They have limited resources or forms of legal protection or social support that they can turn to when encountering such violence and abuse.

My wife's condition was getting worse and worse. I could not speak Thai and I couldn't go anywhere else. Finally I asked someone who could speak Thai to take her to the clinic. The doctor said that she was pregnant and had hypertension and heart complications. He transferred us to the hospital. But, when we went there they asked for her work permit, and when she said she didn't have one they didn't accept to treat her. They said they are afraid of the police. So that is why I sent her back to Burma.
(Burman man, age 30, factory worker in Mahachai)

Chapter 6

General Health Problems and Access to Health Care in Thailand

6.1. General Health Problems

Reports of serious health problems emerged during the in-depth interviews and focus group discussions. Although these were not the focus of this study, it is critical that these realities be noted as they greatly determined the context for understanding the concerns and emphasis (or lack of) regarding reproductive health. In addition to maternal mortality,[41] malaria, injuries, infant mortality, diarrhea and food poisoning, skin rashes, and depression were also identified as common illnesses among the migrants. These particular health problems were then explored further in the survey distributed to participants in Chiangmai and Ranong.

6.1.1 Malaria

Malaria was frequently reported at all the sites, with a disturbing number of deaths among those contracting it. Archavanitkul, et al. (1997) found that malaria is a leading cause of death in migrant communities throughout Thailand. Fifty-six percent of the participants viewed malaria as a serious or extremely serious health problem in their community (Table 6.1). Approximately half of them reported having had malaria. Thirty-five percent (35%) of those in Ranong and 74% of those in Chiangmai said they had contracted the illness within the past six months. Over 70% of those infected at both study sites sought care at a hospital or clinic. In Chiangmai, almost one-fifth of the migrants relied on treatment from traditional healers.

41 This will be discussed in futher detail in Chapter 7.

Table 6.1: Percentage of Participants who Experienced Malaria

Malaria as a Health Problem	Ranong	Chiangmai	Both Sites
% perceived as serious problem	55%	57%	56%
% ever experienced malaria	48%	53%	50%
(N*)	(413)	(409)	(822)
% experienced malaria in last 6 month	35%	74%	55%
(N**)	(198)	(214)	(412)
Place of Treatment:			
- Hospital	17	61	40
- Clinic	62	11	35
- Drug store	6	7	7
- Traditional healer	9	21	15
- Other	3	0	2
- No treatment	3	0	1
Total : Percent	100	100	100
Number**	198	214	412

* Among those who answered the question.

** Among those who experienced malaria.

The following are accounts of how serious migrants viewed their experiences with malaria.

My nephew came down with malaria in Thailand and could not go to the hospital or get treatment anywhere. He went mad with high fever. Malaria got into his brain and he died.
Shan woman, age 21, construction worker in Chiangmai

The main problem here is malaria. If there were medicine here it would be very good. As it is now there is no care in the night and even if there was we don't have the money to pay for it. However, when one can find enough money they still have to worry about meeting police or immigration officers on the way. If we could have medicine here, I think it would be better.
Burman woman, age 17, sawmill worker in Ranong

The incidence of death from malaria seems to be a result of both a lack of understanding of the signs and dangers of the illness and the need for proper treatment, as well as an inability to access available services.

My wife was often sick and we could not go to the hospital because we didn't have any identification cards and couldn't speak Thai well. I borrowed 500 baht from a co-worker and bought some medicine for her. Still she did not get well. Her condition became worse and finally she went mad. She died of cerebral malaria.
Shan man, age 48, construction worker in Chiangmai

One of my children died from malaria. He got ill and his skin turned yellow. He died a few weeks later.
Shan woman, age 21, construction worker in Chiangmai

I have suffered so much from malaria since I came to a different land. I have to receive tonic infusions because I get malaria very often. My health is deteriorating and there is no cure if I have no money.
Tavoyan woman, age 33, sawmill worker in Ranong

6.1.2 Workplace Injuries

Injuries encountered at the workplace were also frequently reported. Forty percent of all participants reported having had an injury, with significantly higher incidences occurring for men than for women. Eighty-eight percent (88%) of migrants in Chiangmai experienced work injuries within the six months prior to participating in the survey, as compared to 56% of those in Ranong (Table 6.2). This is likely attributable to the fact that many participants in Chiangmai worked on construction sites. Of those injured, 32% in Ranong did not seek any treatment whatsoever, and 39% of their counterparts in Chiangmai treated their injuries themselves by purchasing medicine from the local drug store.

Table 6.2: Percentage of Participants who Experienced Workplace Injuries

Workplace Injuries as a Health Problem	Ranong	Chiangmai	Both Sites
% perceived as serious problem	41%	37%	39%
% experienced an injury	39%	42%	40%
(N*)	(398)	(402)	(800)
% experienced an injury in last 6 month	56%	88%	72%
(N**)	(155)	(168)	(323)
Place of Treatment:			
- Hospital	12	28	20
- Clinic	33	23	28
- Drug store	12	39	26
- Traditional healer	8	7	8
- Other	3	3	2
- No treatment	32	0	16
Total: Percent	100	100	100
Number**	155	168	323

* Among those who answered the question.

** Among those who experienced work injuries.

However, findings from the in-depth interviews and focus group discussions indicate that at some workplaces migrants encountered injuries nearly everyday. Many of these were serious, some leading to death.

After working for five or six months in Thailand, my husband fell down a building while working and died. I had no relatives, only some friends to help with the funeral. I was five months pregnant at the time. I told the employer and asked for his help. He gave me 7,000 baht for my child.
Shan woman, age 25, construction worker in Chiangmai

It is easy to get injuries to the hands and feet working at the sawmill. Mostly people hurt or break their arms and legs, but some must have them amputated when logs fall on them.
Tavoyan woman, age 28, sawmill worker in Ranong

When I was working at a sawmill loading a truck, a log fell on my chest. Since then I cannot do hard work and had to change my job because my chest hurts inside.
Mon man, age 23, laborer in Mahachai

I was working at an iron industry and an iron pipe fell on me. The employer didn't do anything so I just had to stop working and rest. I just hope that I will get better. It has already been seven days and I still cannot work.
Burman man, age 22, factory worker in Mahachai

6.1.3 Depression, Stress, and Anxiety

The migrants participating in this study frequently described symptoms of depression during in-depth interviews and focus group discussions. When asked about symptoms of depression, two-thirds of all participants reported having stress, depression, or anxiety (Table 6.3). Among those with these symptoms, incidents within the past six months were high for migrants at both sites (77% in Ranong and 96% in Chiangmai). One-third of the Chiangmai participants sought support from monks at the local Shan Temple to help reduce stress or depression, while migrants in Ranong, for the most part, did not seek help for their stress.

Table 6.3: Percentage of Participants who Experienced Stress/Depression/Anxiety

Stress/Depression/Anxiety as a Health Problem	Ranong	Chiangmai	Both Sites
% perceived as serious problem	31%	39%	36%
% ever experienced depression	65%	65%	65%
(N*)	(377)	(403)	(780)
% depressed in last 6 month	77%	96%	89%
(N**)	(244)	(262)	(506)
Place of Treatment:			
- Hospital	4	6	5
- Clinic	1	1	1
- Drug store	0	12	6
- Traditional healer	-	10	5
- Temple/monk	1	37	19
- Other	16	34	25
- No treatment	78	0	39
Total: Percent	100	100	100
Number**	244	262	506

* Among those who answered the question.

** Among those who experienced depression.

I am very tired and I want to go back home. I could not work this kind of job in Burma and now I am working like a slave here. I feel very sad and cry sometimes. I used to have a private business in Burma where I asked people to work for me. Here I am a slave. I think about this and I can't stop crying.
Burman woman, age 28, factory worker in Mahachai
Sometimes I feel so very depressed, especially when I also have health problems. My main

problem, however, is economic. Also, sometimes my husband and I quarrel. I don't say anything until he calms down and we can try to understand each other. But, mostly I don't talk to any one, I just stay quiet.
Burman woman, age 28, shrimp factory worker in Mahachai

6.2. Access to Electricity and Tap Water

To highlight the living conditions faced by the participants, access to basic services such as electricity and tap water was investigated. Although the majority of the Thai population living in the same areas had access to safe water and electricity, migrant communities were often isolated and segregated with limited access to these services.

The study found diverse environmental conditions among and within the various sites. In Chiangmai, migrants had far greater access to electricity and tap water (Table 6.4). Ninety-five percent (95%) of households had electricity and 88% had tap water compared to 72% and 37% of Ranong residents, respectively. The type of work and residence did not affect access to electricity or tap water in Chiangmai. However, this was not true in Ranong. The migrants living in the Ranong port area who worked in fish processing factories had greater access to electricity (98%) than did workers in sawmills (67%) and on plantations (46%). Differences were more striking when exploring access to tap water. Sixty-two percent (62%) of fish processing workers were able to obtain tap water compared to 31% of plantation workers, and 11% of sawmill workers.

Table 6.4: Percentage of Participants Having Access to Electricity and Tap Water According to Study Site and Occupation

Ranong	Saw Mill (n=145)	Plantation (n=101)	Fish Processing (n=169)	Total (n=415)
% Access to electricity	63%	40%	98%	72%
% Access to tap water	11%	31%	62%	37%

Chiangmai	Factory (n=90)	Construction (n=229)	Service (n=90)	Total (n=409)
% Access to electricity	93%	96%	96%	95%
% Access to tap water	89%	86%	91%	88%

Access to electricity and tap water, however, did not necessarily indicate decent living conditions. From observation and field notes taken by researchers, environmental conditions, such as cleanliness and sanitation, were better on plantations than in sawmills or construction sites. Overcrowding in the sawmills and on the construction sites exacerbated the already difficult living conditions, which was not an issue on the plantations.

Where we live now, the electricity has been cut off for four days already. I heard the boss didn't pay the electricity bill and said he would pay it today. So, hopefully the electricity will come back tomorrow. We don't have any water in the meantime. This is a big problem.
Shan woman, age 21, construction worker in Chiangmai

We don't get good water on the site where we live. Whoever uses this water gets skin rashes. The water source is filed with garbage and the water in the tank is pumped from that well.
Shan woman, age 19, construction worker in Chiangmai

The employer doesn't give us water or electricity. I take my bath in the river and also use that water for cooking. As for toilets, no toilets here. Just go wherever is convenient.
Tavoyan woman, age 46, farm worker in Ranong

The wells and toilets here in the orchard are not clean. The Health Department came and constructed water toilets. We get the water from the stream.
Tavoyan woman, age 28, farm worker in Ranong

The water here is sold to us from water trucks. The toilet had to be built by us. There is a stream nearby which is like a drain so it was convenient for building a toilet.
Burman woman, age 26, sawmill worker in Ranong

Although Chiangmai participants reported access to tap water and electricity, the quality and consistently of these services was erratic. During in-depth interviews and focus group discussions, migrants in Chiangmai frequently reported skin rashes and dysentery as a result of poor water quality or limited access to water and electricity (Table 6.5). Approximately one-third of the participants at both sites had experienced skin diseases, presumably a consequence of temporary living arrangements and frequent mobility. Fifty-three percent of all participants had gotten diarrhea and among them 80% of those in Chiangmai had experienced it at least once in the past six months, as compared to 49% in Ranong.

Table 6.5: Percentage of Participants who Experienced Skin Diseases and Diarrhea

Skin Diseases and Diarrhea as Health Problem	Ranong	Chiangmai	Both Sites
Skin Diseases/Rashes			
% ever experienced	32%	30%	31%
(N*)	(401)	(401)	(802)
% experienced in last 6 month	53%	79%	66%
(N**)	(128)	(122)	(250)
Diarrhea/Dysentery			
% ever experienced	52%	54%	53%
(N*)	(409)	(402)	(811)
% experienced in last 6 month	49%	80%	65%
(N**)	(213)	(215)	(506)

* Among those who answeted the question.

**Among those who expetienced skin diseases or diarrhea

We need some good water in this area. Everyone who uses this water gets skin rashes. The water source (well) is filled with garbage. The water in the tank comes from that water source.
Shan woman, age 19, construction worker in Chiangmai

The river is the toilet and the children get diarrhea more often than the adults do.
Burman woman, age 28, farm worker in Ranong

Here the water has to be bought and when the money runs out there is no water. Then there is a lack of hygiene and someone is always sick.
Tavoyan woman, age 18, sawmill worker in Ranong

The tap water is not good to drink. There is also mosquito larva in the drain water. It is dangerous and not good for our health to live here.
Burman man, age 23, driver for a shrimp factory

My son has skin allergies. The doctor at the clinic gave him medication, but he still hasn't improved.
Shan woman, age 21, construction worker in Chiangmai

About ten days ago, over 60 people at this site were all sick at the same time. No one could go to work. Finally, the employer took us to a clinic to get some medicine.
Shan woman, age 34, construction worker in Chiangmai

My brother died of food poisoning after arriving in Thailand. Now my sister-in-law stays with us.
Shan woman, age 40, construction worker in Chiangmai

Several women and children reported being in poor health and sick, often not knowing the cause of their illness.

I get sick often and I am jaundice. My youngest son is also often ill. Last month both my son and I were very sick and only my husband could work.
Shan woman, age 21, construction worker in Chiangmai

My daughter is often sick. She is not very healthy.
Shan woman, age 25, vendor at a construction site in Chiangmai

I cannot see out of my right eye. I got very sick when I was around ten years old. Someone was working black magic on my parents, but the effect was on me instead.
Shan woman, age 19, construction worker in Chiangmai

I have been suffering from some kind of itching as if something is wrong with my blood. I cannot wash any clothes because my hands itch so much when I do. They said it has something to do with my blood.
Shan woman, age 19, construction worker in Chiangmai

6.3. Health Care in Thailand

The majority of migrants addressed their health care needs by purchasing medicine at the local drug store or seeking out traditional caregivers and healing methods.

There is a traditional healer nearby. So I just tell her what is wrong in my body and she will take care of it. She doesn't do any check up because she has no instruments. I have to pay according to the charges she asks for. It can be expensive. For example, it can cost up to 500 baht if someone needs intra-venous transfusion and an injection costs about 300 baht.
Burman woman, age 20, shrimp factory worker in Mahachai

We live in an orchard and when my child is sick I go to the old lady here. She usually boils beetle leaves with a little bit of salt to cure the baby from a cold or illness. The old lady also helped deliver a baby here. But the mother died three days after the delivery because of sepsis. The baby is now one year old and lives with the father.
Mon woman, age 22, farm worker in Ranong

I married my wife here at the construction site. During her pregnancy and through her delivery we never went to see a doctor. This is because we do not have any identification card and

so we cannot ask anyone for help. Fortunately, there was a traditional Shan midwife at the construction site who helped with the delivery.
Shan man, age 40, construction site in Chiangmai

When we are sick we dare not go to the hospital. We only ask people to buy medicine for us. Sometimes we get better and other times we are worse. Everyone has experienced this situation.
Shan man, age 44, construction worker in Chiangmai

It is too difficult to go the clinics so we just buy the medicine or injections ourselves. Then I find someone to give me the injection.
Tavoyan man, age 39, worker on a cashew nut farm in Ranong

I was a nurse in Burma and so sometimes people come to consult me. Sometimes they try to treat themselves and when things go wrong they come to see me. I don't like to work this way. Some women do not have jobs, so they have no food and become weak or feel dizzy. I have to give them a vitamin injection. I also give medical treatment for some women and help prepare them for their delivery. I don't like to provide deliveries because I am afraid something might go wrong. But, often they ask me to. I encourage them to find someone who can speak Thai and go to the hospital. The problems are so many. I do if I can and I don't do if I can't. My brain is unbearably confusing and overwhelmed.
Tavoyan man, age 40, shop seller in Mahachai

We go to one pharmacy in Ranong to buy and take the medicine ourselves. There are Burmese working there. They are not doctors but they can speak Burmese.
Tavoyan woman, age 43, gardener in Ranong

We don't have a doctor so we just have to take medicine. The Thai lady's shop over there is where we buy medicine. She is nice and helps us decide what medicine to take when we are sick.
Tavoyan woman, age 18, sawmill worker in Ranong

Legal status, financial savings, and ability to communicate in Thai (or find an interpreter) were the main factors determining migrants' health care decisions. During in-depth interviews and focus group discussions participants at each site consistently discussed how these factors impacted their ability to seek health care.

We have no identification cards to go to the hospital and we don't speak Thai very well. We have to buy medicine from the drug stores and treat ourselves, and sometimes it gets worse. I have seen people get so sick they have to go to the hospital. They have to hire other people to accompany them to the hospital, pay for transportation, and expensive hospital fees. Everyone tries to buy medicine to take care of themselves because it costs so much money to go to the hospital.
Shan man, age 34, construction worker in Chiangmai

People without an ID card die. A girl who lived by the stream died from excessive bleeding. One cannot rely on the business owner. If you have no money or ID you just die.
Mon woman, age 16, farm worker in Ranong

My friend miscarried and went to a clinic for one day. Then she was arrested. I don't know who told the police.
Indian man, age 24, porter for a shrimp factory.

If you have a health problem, you better have a lot of money. You have to spend a lot of money for the clinics and hospitals if you are not in good health. In addition, if you cannot speak Thai and explain your condition, you will not receive suitable treatment. In addition, we have to be aware that we are illegal in this country which makes it difficult to access medical treatment.
Burman man, age 22, factory worker in Mahachai

I get paid 145 baht a day. If I am sick or injured I don't get paid and it is very difficult to go to the hospital. In order to go to the hospital we must encounter traffic lights, policemen, and checkpoints. We are poor and afraid which makes it difficult to get health care.
Indian man, age 24, porter at a shrimp factory in Mahachai

I can do whatever I want if I have money. I can buy and take medicine if I have only a little money. Even for an injection I can buy cheap or expensive ones and inject it or infuse it.
Burman woman, age 30, shrimp factory worker in Mahachai

It doesn't make much difference even if I could go to the hospital. The hospital would charge 3,000 to 4,000 baht and I have no money.
A Burmese man, age 22, factory worker in Mahachai

If you have money then you can deliver in a hospital. If you don't have money they you give birth here and we help each other. If it is a difficult birth we call the ma phyu [midwife]. She has birthed many women here.
A Dewai woman, age 28, sawmill worker in Ranong

The woman next door is sick sometimes. She just takes some medicine and goes to sleep. She doesn't go to a doctor as the clinic is too far away. We don't know our way around and can't speak Thai very well. If I get sick I will do the same as her.
Shan woman, age 24, construction worker in Chiangmai

With one or a combination of these skills or resources (language, documentation or money) migrants were able to seek health care services. Many migrants requested this support from their employer, especially in emergency situations.

The employer took me once to the hospital when my child was sick and he paid 150 baht. Another time the employer took me to a clinic to get an injection after I stepped on a nail. He paid the fees.
Shan woman, age 32, construction worker in Chiangmai

Sometimes we tell the boss we need to go to the doctor. If that person is very close with him, the boss sends for a car. If not, than they have to go find a bus and pay for themselves.
Mon man, age 36, sawmill worker in Ranong

Once I saw a worker whose hand was injured. He needed medical care. But when the employer's son saw his injury he said 'just cut off the hand.' Maybe he was kidding, but the worker felt unhappy and was unable to get any care.
Tavoyan man, age 39, sawmill worket in Ranong

The employer took me once to the hospital for my stomach pains and they gave me some medicine to drink. He paid for everything. I have received two traditional Shan massage treatments also. But the pains still come. I have no money to go back and I don't want to ask the employer again.
Shan woman, age 33, construction worker in Chiangmai

If it is a life or death situation, the boss downstairs will take us to the hospital. For example, one Burmese man arrived with malaria and was absolutely unconscious. Most outsiders would consider him a hopeless case but the boss took him to the hospital and the patient recovered. If it wasn't for the boss, well the patient would have died. But, now I am not healthy and I want to go to get some help, but the employer will not help. The work provides no regulations or guarantees.
Burman man, age 30, factory worker in Mahachai

This factory is good. If there is something wrong you can go to the clinic. If they can't treat you the supervisors will take you to the hospital. The factory will pay for the costs.
Burman woman, age 28, factory worker in Mahachai

I was lucky that I had been in Thailand for awhile and could already speak some Thai when I got injured. I sprained a tendon in my back at work and could not get up for seven days. I had no friends to take care of me and the employer never came to take a look. I had to depend only on the employer to help, if he wouldn't there was nothing I could do. Luckily a Thai teacher came and took me to a clinic. I stayed there for fifteen days at my own expense. When I got better I had to ask my employer for a loan and agreed to work for him until I had paid all the money back. These health problems are so difficult.
Mon man, age 23, factory worker in Mahachai

If you have financial problems when you are sick you can ask the boss for help. They will vouch for you and help translate too. Things are much easier if the boss speaks for you. In

Burma, too, if the boss helps like this there is the understanding that you must be humble and offer your gratitude. Nothing comes free. The costs you run up depend on how sick you are.
Tavoyan woman, age 18, sawmill worker in Ranong

When we need health care the boss will send us to the clinic. They will pay in advance and then deduct the money from our wages.
Tavoyan woman, age 42, sawmill worker in Ranong

The migrants interviewed reported using both public and private health care services. Private clinics were frequently chosen because of their proximity and anonymous nature.

When my daughter is sick I take her to the clinic. Each trip costs at least 200 baht. At first the doctor asked all kinds of questions and I could not speak Thai very well. But, since my daughter is often sick, the clinic has issued a medical card for her. I am lucky to find such a good clinic.
Shan woman, age 25, construction worker in Chiangmai

When I worked in Bangkok I went to a clinic when I was sick. The clinic staff took me upstairs and dripped a bottle of salt liquid into me and gave me some tablets. You know he charged me 1,400 baht. As I was leaving a doctor came in. He looked at my medicine then checked me. Then he gave me a vitamin injection and changed the tablets that the other man had given me.
Karen man, age 26, plywood factory worker in Mahachai

Public services, however, were primarily sought for emergencies only or for childbirth deliveries.

My wife had a great fall and hit the ground so hard. We took her to the hospital because she was seven months pregnant at the time. The doctor said the baby was dead and he used a machine to suck the baby out. We had to pay 5,000 baht for the service.
Shan man, age 29, construction worker in Chiangmai

One day a machine split my husband's right finger. He had to go to the hospital. They charged him 3,000 baht and the construction company compensated him 2,700 baht. He could not work any more in that job so we left.
Shan woman, age 25, construction worker in Chiangmai

A friend who had been in Thailand for a long time brought me to the hospital in Chiangmai. I delivered there because the baby's bottom came out first and I could not deliver normally. The doctors had to operate. They told me I could only have two children. I was also given one bottle of blood transfusion. It cost 4,800 baht. My husband's boss admitted me to the hospital to give birth. I had a beautiful and healthy baby girl.
Shan woman, age 21, construction worker in Chiangmai

My sister gave birth to twins at the Ranong hospital. I visited her there. She had problems because the doctors asked for her documents, which she didn't have. The clerk tried to explain that she accepted the woman because she was in labor. That is when the doctor and the clerk got into an argument.
Mon woman, age 27, sawmill worker in Ranong

Migrant workers in Ranong had an additional option of returning across the border to Burma to seek health services in Kawthaung.

We cannot speak Thai very well and are afraid to be arrested. So it is better to go over to the clinics in Kawthaung. The clinics are cheaper there as well.
Tavoyan woman, age 25, sawmill worker in Ranong

When I get sick I take Burmese medicine. If I do not get better I will take western medicine from the store over there. If it is serious and you have money you can go to Ranong. If you don't have enough money then you must go back to Kawthaung in Burma.
Mon woman, age 27, sawmill worker in Ranong

My wife's condition was getting worse and worse. I could not speak Thai and I couldn't go anywhere else. Finally I asked someone who could speak Thai to take her to the clinic. The doctor said that she was pregnant and had hypertension and heart complications. He transferred us to the hospital. But, when we went there they asked for her work permit, and when she said she didn't have one they didn't accept to treat her. They said they are afraid of the police. So that is why I sent her back to Burma.
Burman man, age 30, factory worker in Mahachai

For those migrants who were able to access health services in Thailand, many reported discriminating attitudes among the providers.

When my friend's foot was cut the employer sent him to the hospital. I stayed and took care of him there. I had to ask for everything for him. I could see this was not the same for Thai patients. I even had to ask for a pillow and I was told that the Burmese pillows smelled very bad and were very dirty.
Burman man, age 26, plywood factory worker in Mahachai

If the employer takes us to the hospital, then the Thai doctor will treat us. But, it is different for Burmese than Thai. It depends on your Thai language abilities. If you don't understand them, there can be problems and they will not treat you well.
From a focus group discussion among male and female migrants with a Thai doctor in Mahachai

At some plantations in Ranong, migrants reported that health care providers provided outreach services to their communities.

There are health assistants who come here and give us medicine, but for serious problems we have to buy our own medicine. We buy some and store it in case of an emergency. Otherwise we just order medicine or injections from people who are going to the market.
Tavoyan woman, age 33, sawmill worker in Ranong

Overall, migrants feel that they are not able to easily gain access to health services in Thailand unless they have legal status, financial resources, and/or Thai language skills or translation. Many migrants fail to seek health care services or wait until their health deteriorates considerably, which often leads to life threatening consequences. The number of deaths reported among migrants was quite high considering the health care establishment's ability to treat health problems such as malaria or complications in delivery, or early childhood illnesses. Child mortality was noted as a major health problem by many of the study's participants.

My oldest son died when he was three years old. Nothing was wrong in the morning, but by the afternoon he suddenly felt sick and died. His body was blue all over and people said that it was the influence of the evil spirits. Another one of my children died in Shan State four days after I gave birth at home. So, out of four children two have survived.
Shan woman, age 40, construction worker in Chiangmai

Last month two children in our community died. They were from the same family, one girl was seven years old and the boy was just three. No one knows what disease they died of because they were too poor to go to the hospital. Today there is another funeral for the death of another child.
Tavoyan woman, age 28, sawmill worker in Ranong

Many migrants spoke of the need to guarantee immunity from arrest when seeking basic health services, translation services, and referral mechanisms with traditional or community-based care providers.

I think it would be good to have clinics and hospitals that can treat Burmese people.
Burman woman, age 26, sawmill worker in Ranong

It makes a Burmese person so mentally exhausted going to a hospital or clinic in Thailand. These places will be convenient if you go with a representative because if you cannot tell them what is wrong the medicines they give you will not be compatible. It would help if there could be some health services for Burmese. Ideally, for the Burmese staying here we need a Burmese doctor or Burmese person who has knowledge in medicine. If there is someone we don't have to take so many risks. We don't need anything else.
Tavoyan man, age 26, sawmill worker in Ranong

The migrants need health care. I can help them as much as I can, but what to do when I cannot help? Some go back to Burma, but others cannot. We need to have clinics and hospitals that can communicate and accept the Burmese.
Mon woman, age 22, farm worker in Ranong

There are several non-governmental organizations (NGOs) in both Chiangmai and Ranong that have attempted to offer basic health services in certain areas. In addition, a clinic for migrants from Burma was opened in Mahachai, but was unable to sustain its operations.

Once when I was shaking with malaria some health workers found me wrapped up in a blanket. The health workers were there to tell the workers about HIV/AIDS but when they saw me they put me in a car and took me to the malaria center. They tested my blood and the hospital staff said that if I had been any later in getting to the hospital I would have died. I had cerebral malaria. They gave me medicine and I took it as they instructed. After some time I was better. The health workers who took me there paid for everything.
Shan man, age 29, construction worker in Chiangmai

6.4 Concluding Remarks

Serious health problems among the migrants interviewed for this study included malaria, workplace injuries, diarrhea, skin rashes, and depression. Deaths were often reported as a result of giving birth, malaria, workplace injuries, and unknown causes of child morbidity.

Malaria was most frequently reported at all three sites. The incidence of death from malaria was high and appeared to be a result of both a lack of understanding of the signs and dangers of the illness and the need for proper treatment, as well as an inability to access available services. Injuries encountered at the workplace were often reported, including fatal injuries. Migrants also frequently described symptoms of depression and stress. In addition, their inability to access clean and safe water exposed them to a high risk of diarrhea and skin diseases. Even those who had access to tap water were not immune from these diseases.

The mains factors determining migrants' decisions to seek health care or not were their illegal status, financial savings, and inability to communicate in the Thai language. The majority of migrants first sought to address their health care needs by purchasing drugs or seeking traditional caregivers or healing methods. Many migrants saw assistance from their employers (providing the necessary negotiation and/or financial support) as the only means of accessing health care providers, public or private. Public health services were identified as primarily available only for emergencies or childbirth deliveries. Private health services were reportedly preferred because of their proximity and anonymous nature, although they were usually more expensive. Migrant workers in Ranong had the additional option of returning across the border to access health services in Burma.

Many migrants explained the general trend in their community was to avoid seeking health services until one's health deteriorated and faced a life-threatening situation. They noted the need for an amnesty from arrest when seeking health services, translation

services, and referral mechanisms with traditional or community-based health care providers. A few NGOs have attempted to provide some of these services, but have had varying degrees of success.

When I had an abortion a Mon woman inserted flat bamboo sticks into my uterus. Actually I didn't want to use sticks because I was afraid of cancer, but she assured me she wouldn't use them. Then she told me to lie down and inserted those bamboo sticks and poked only twice. There was a sudden discharge and then she said it was done. I was barely conscious when I left and still bleeding heavily. When I finally went to the hospital I had stopped bleeding and they gave me some vitamins and medicine to treat the damaged uterus. When I got home I started aborting the actual fetus.
(Tavoyan woman, age 43, farm worker in Ranong)

Chapter 7

Sexuality and Reproductive Health

7.1. Sexuality

The underlying beliefs and behaviors in relation to sexuality provide a basis for understanding reproductive health perspectives, concerns and needs. Therefore, a wide range of issues that influences one's sexuality and choices were discussed with the participants. However, the survey did not address many aspects of sexual health, as the researchers found that many of the questions were inappropriate given the fact that they had not established a bond of trust with the participants, particularly the females. In addition, many aspects of sexuality were rarely discussed among the migrants themselves.

During the in-depth interviews and focus group discussions, participants often noted the difficulties and constraints in discussing issues of sexual and reproductive health.

My parents told me sex is like what the dogs do, but people don't let anyone see them.
Shan man, age 22, construction worker in Chiangmai

I haven't talked about sex with anyone. The subject is so embarrassing.
Shan woman, age 27, construction worker in Chiangmai

I feel ashamed to talk about sex.
Burman woman, age 17, fish canning factory worker in Mahachai

Limited information and inability to freely discuss sexuality and reproductive health issues was found among the participants at all three sites, though to varying degrees according to gender and level of education.

7.1.1 Gender Differences of Perceptions Towards Sexuality

While male participants were more able to openly talk about sex, they frequently reported lacking critical information about sexuality and reproduction health.

> *Men don't know much about women's health. I think women have their menstruation about twice a month. When married women stop having their blood they are pregnant. For some women when their menstruation stops for a long time they go to the doctor to get an injection to induce the menstruation.*
> Arakan man, age 36, cashew nut farm worker in Ranong

> *Women's menstruation comes once a month. If they sleep with men, the menstruation will not come at all or sometimes just a little bit. When the menstruation doesn't come regularly she can take medicine, but I don't know what kind. Sometimes women can have red circles on her skin, but these will be gone after taking the medicine.*
> Burman man, age 30, factory worker in Mahachai

Some participants were more knowledgeable than others about sexual health and reproduction, though there were still several aspects they were unfamiliar with. These participants represented a minority of all those interviewed. Largely from central Burma, they were literate in the Burmese language and had received a number of years of formal education.

> *If a woman is not sterilized and has sex with a man who is not sterilized they can reproduce. However, if one has a weakness, she may not get pregnant. I know about this because I am educated. I read books and articles. And now, I am a nurse here.*
> Burman woman, age 37, informal health provider in Mahachai

> *I have read a health education book. If men and women have sex three days before or after her egg comes down (the middle of her cycle) she can get pregnant. During the other days she can only get pregnant if the woman's womb is squeezed after the man's sperm enters.*
> Burman man, age 34, plywood factory worker in Mahachai

7.1.2 Virginity

Commonly accepted sexual norms for men and for women varied greatly, with a strong emphasis placed on virginity for girls and women. Virginity was seen as closely tied to the value of a girl or woman as a person and partner. While some participants noted the value of virginity for males, no respondent gave it the same importance in determining a man's character or value, especially in terms of respect.

> *It is very important for a woman to be a virgin before marriage. If I had pre-marital sex with another man I am afraid my husband would say degrading things about me when we have a fight. Since I was a true virgin, my husband values and treats me well.*
> Shan woman, age 19, construction worker in Chiangmai

What woman would have pre-marital sex? If something happens, all the bad consequences will be on her. That is why we have to control ourselves. People will look down on us otherwise.
Burman woman, age 32, sawmill worker in Ranong

If a woman has sex before marriage she will lose face in her community. The others will look down on her. She will be ashamed. There is not this problem or worry for boys. They can live as they like.
Tavoyan woman, age 25, sawmill worker in Ranong

Men don't need to be valuable for that [virginity], but girls must keep their value in many aspects. Girls must control themselves and keep their integrity. She must keep away bad things that should not happen. Boys can do no wrong and girls must suffer if they make a mistake. Boys are not spoiled by dirty stuff.
Tavoyan woman, age 33, sawmill worker in Ranong

It is best for men and women to maintain their virginity, but us men usually do not take it seriously.
Shan man, age 34, construction worker in Chiangmai

Loss of virginity for girls and women before marriage usually resulted in serious consequences, such as early or forced marriages, or if pregnant, abortion and/or isolation.

I knew nothing when I was four months pregnant. My boyfriend went away for awhile and my mother forced me to have an abortion.
Shan woman, age 29, construction worker in Chiangmai

My friend slept with her boyfriend and got pregnant. She said she did not want to but he took her by force. Her boyfriend's parents did not approve so he asked her to abort. Even if the girl doesn't want to have sex and the man forces her, she cannot do anything. I think if the man forces her, he should marry her.
Mon woman, age 27, sawmill worker in Ranong

Before my husband and I were married we would meet secretly every night. When the elders found out we were forced to marry.
Shan woman, age 21, construction worker in Chiangmai

7.1.3. Sexual Intimacy

The discussion above provides the background for understanding the sexual intimacy and experiences of the participants. The emphasis on virginity is closely tied to a specific understanding of male and female sexuality in which men are considered by nature to be more sexually active and the initiators in sexual matters. Excerpted below are discussions of sexuality both before and during marriage.

Sex before marriage is the woman's fault. Men being men 'will eat if they see food.' The fact is, if there is a problem, they won't take responsibility. After all she is not his wife. So, it's the woman who has to suffer and bear the cost.
Burman woman, age 26, sawmill worker in Ranong

I didn't know what would happen when we slept together. It was my husband who taught and told me everything about sex and pregnancy.
Shan woman, age 32, construction worker in Chiangmai

My husband is older than I and he taught me everything I know about sex. He got some knowledge from reading books in the Burmese language on sex education.
Shan woman, age 33, construction worker in Chiangmai

Most men prefer more than one sexual partner, but they should be controlled by religion. Anyway, every man wants to have more than one because they like to have different meals. If they don't do it is because of practicalities.
Mon man, age 26, plywood factory worker in Mahachai

I met one woman who married when she was 14 years old. Because she married too young they say her 'sexual pot burst' and she could not stay without having sex. How disgusting to see a woman whose 'sexual pot burst.'
Shan woman, age 25, construction worker in Chiangmai

Yet, there were also participants who shared a sexuality that was mutually responsive.
He's my husband and I'm his wife. If we agree we come close. If there is no agreement we don't.
Tavoyan woman, age 28, farm worker in Ranong

We have a good sexual relationship. No problems at all. We have never discussed anything about sex. I only know about my husband's feelings. I only know one thing that we love each other and got married.
Mon woman, age 38, factory worker in Mahachai

Underlying sexual norms and double standards, however, remained prominent. It was assumed that men had a greater sexual drive than did women. Many female participants described trying to meet this need in order to keep harmony in their marriage.
Even though I am not interested, I must fulfill his wishes because we are husband and wife.
Tavoyan woman, age 43, gardener in Ranong

If I don't give it to him he usually gets angry. But, I'm usually not in the mood. But, I don't care. If I don't sleep with him, he thinks I must be sleeping with another man. So, I let him sleep with me. I don't want to start problems.
Tavoyan woman, age 20, sawmill worker in Ranong

7.1.4. Attitudes to and Practices of Purchasing Sex

The majority of participants described commercial sex patronage as a common social event for men. Female participants in Chiangmai perceived it as a less prevalent activity than did the men, who openly discussed their personal experiences. Men in Chiangmai were also more candid in discussing commercial sex than their counterparts in Ranong. At both sites, commercial sex patronage occurred as a group activity with men and their peers going together to visit sex workers, usually after a night of drinking.

> *When I drink and become drunk, I just go wherever friends ask me to go ... festivals, any place, I will follow them. It is not strange, quite normal. I get drunk. When I come back home I sober up. Nothing has changed. Just wasted some money.*
> Mon man, age 16, farm worker in Ranong

> *After they [men] spend about three or four months at sea, they come back wanting to drink and go to sex places. This is their one way of relaxing.*
> Tavoyan woman, age 25, sawmill worker in Ranong

Social norms were supportive of single men frequenting commercial sex outlets; both male and female participants expressed an acceptance of this behavior.

> *Visiting prostitutes is nothing strange or abnormal. It is just a simple practice for those who are not married and have no girlfriends or lovers. It is acceptable to many.*
> Shan man, age 29, construction worker in Chiangmai

> *It is popular for men to go to brothels because they are men. Men will definitely take what is offered. Women should control themselves. Men will take advantage only if women open the way for them. It depends on the women. We cannot criticize the men about this.*
> Tavoyan woman, age 46, farm worker in Ranong

Having multiple partners was also common for married men, although it was less socially accepted. While the practice for single men was considered "natural", such behavior on the part of married men was attributed to marital problems or men needing new and fresh faces.

> *Some men have problems with their wives. They have problems in family circumstances or financial conditions. Sometimes their wives scold them, so they are very disappointed and cannot put up with their wives. They go to hotels, bars, and restaurants to seek pleasure from other women.*
> Tavoyan woman, age 28, sawmill worker in Ranong

> *The men with wives, they can have sex all night with their wives. What's the difference? All women are the same. Only their faces differ. If these men weren't involved, women too wouldn't*

get corrupted. Only a system of monogamy is good. But they say they're bored with their wives. They (prostitutes) are not the same as the women at home, they say. One doesn't get tired of those women, they say. The wives at home, with their string of babies are boring, they say. They look forward to visiting brothels.
Tavoyan woman, age 37, sawmill worker in Ranong

I will tell you about my experiences with prostitutes. If a woman has to have sex with the man whom she had already had several times before, she would feel free to enjoy it and would be responsive and creative and when she reaches orgasm her behavior would be even more fierce than that of a man. But with a new man, a complete stranger, she would be reserved and be afraid to show her genuine feelings. For most men, it is just the other way around, like the palm and the back of the hand.
Shan man, age 48, construction worker in Chiangmai

If a man wants to have more than one partner, he should not get married. If he wants to be married, he should stop fooling around.
Mon woman, age 27, sawmill worker in Ranong

As for single men, they go because they don't have wives. But for married men, they shouldn't go. But no one can go and stop them. They lead our way. We just stay at home. We can't know where they go. We know only after being told by others. Only if you go and see for yourself, you come to know what your husband is doing. The children and wives are left just at home.
Burman woman, age 33, farm worker in Ranong

When disapproval of commercial sex patronage for married men did occur it was often grounded in economic concerns. Female participants frequently stated that commercial sex patronage was "a waste of hard earned money."

I think men who go to prostitutes care only about pleasure, they don't understand or think about the economic situation. They are just spending money unnecessarily.
Burman woman, age 32, sawmill worker in Ranong

Nowadays both here and in my home village, it is common for men to have sex with prostitutes. If their girlfriends do not sleep with them, now they can go to prostitutes. Here at this mill, every night the men go. They go to Kawthaung. All the single ones and also the ones with wives. Their wives are not here. They are left behind in Burma. They go because they don't have their wives here. I hate it. They don't think about how to support their wives. They are thinking about spending money on the prostitutes. But the singles, they want to have fun. They have to spend the money. I tell them instead of going to prostitutes why don't you just get married. But they say that there is no one to get married to.
Mon woman, age 27, farm worker in Ranong

My husband visits prostitutes. I told him it is a waste of his money, but I am afraid of HIV. But he still goes and I cannot stop him.
Shan woman, age 25, construction worker in Chiangmai

Thirty-one female survey participants discussed their spouses' visits to commercial sex establishments, as did several women during in-depth interviews. Most of these women noted that they were unable to prohibit their spouses from such patronage and as a result suffered emotionally.

At the present time, my husband likes to visit prostitutes. He goes when he gets his wages, and sometimes his friends pay for him. I am so upset whenever I think about it that I forget what I am doing. We have a child together. ... I am sick at heart and mentally disturbed because I have been long oppressed and bullied by him. He did not say how he liked our sexual relation to be and when I asked questions, he would scold me and say that I am too talkative. He said that men have the right to take minor wives and visit as many women as they like.
Shan woman, age 40, construction worker in Chiangmai

During last Thingyan (Buddhist New Year), he went to Kawthaung with his friends to the 'shops' [sex outlets]. He said he didn't get close to the girls. But I was really afraid and didn't want to let him go there since they [commercial sex workers] might have diseases. We had an argument about it. He goes there often. I don't dare to ask about it. It's just not good.
Mon woman, age 27, sawmill worker in Ranong

Survey data revealed that 30% of all male participants in the study had had sex with a prostitute in their lifetime. Of these men, 82% had procured sexual services in Thailand. Within the past six months, 75% of the men who had had a sexual encounter with a prostitute had frequented a commercial sex establishment from one to twelve times. Friends accompanied the majority of those visiting commercial sex establishments (85%) during their most recent visit.

Marital status appeared to influence men's experience with sex workers, though there were notable differences between the study sites (Table 7.1). In Ranong, the proportion of those who had ever bought sex was highest among 'once-married' men (divorced, widowed, or separated (38%). In Chiangmai, on the other hand, the highest proportion was among single men (59%). Forty-seven percent (47%) of 'once-married' men in Chiangmai had a least one sexual experience with a sex work, as compared to 20% of married men. Single men in Chiangmai were 2.2 times more likely than their counterparts in Ranong to have ever visited sex workers. Almost all currently married women (85% in Ranong and 98% in Chiangmai), however, claimed that their current partner had never frequented sex establishments.

Table 7.1: Percentage of Male Participants who Bought Sex According to Marital Status and Study Site

Buying Sex	Never Married	Currently Married	Never Married	Total
Ranong				
% ever bought sex	27%	21%	38%	31%
(N)	(82)	(96)	(13)	(194)
Chiangmai				
% ever bought sex	59%	20%	46%	53%
(N)	(56)	(108)	(15)	(188)

7.1.5. Multiple Sexual Partners

There were also relationships that fell between the spectrum of 'wife' and 'sex worker.' Sixteen percent (n=68) of women and nine percent (n=35) of men believed that their current partner was involved in other sexually intimate relationships (Table 7.2).

Table 7.2: Percentage Distribution of Participants' Perceptions about Current Partner

Perceptions towards Current Partner	Women	Men	Total
Believes Partner has Other Lovers	16	9	13
Believes Partner is Monogamous	70	63	67
Not applicable*	11	18	14
Don't Know	3	10	6
Total : Percent	100	100	100
Number	424	394	818

* No partner at present time.

In an effort to explore relationships beyond the dichotomy of spouse and sex worker, we discussed intimate relationships with the opposite sex by requesting the participants to discuss intimate ties (limited to three) that were present during the past year. These ties did not necessarily involve sexual intercourse, though in many cases they did. Seventy-seven percent of all the participants (n=646) provided details on a total of 828 intimate ties, of which 664 (80%) included sexual contact. Table 7.3 shows the relational types discussed by the participants. The majority of the ties mentioned were spousal relations: 57% in Ranong and 65% in Chiangmai. This fact explained the high percentage of intimate ties that contained sexual contact. In this category, spouse was the main partner who most often shared residence with the participant,

whereas lover or minor partner implied a stable and physically intimate relationship. Boyfriend/girlfriend also indicated a steady relationship, but between unmarried individuals.

Table 7.3: Percentage Distribution of Intimate Ties According to Relational Type

Relational Type	Ranong		Chiangmai	
	Women	Men	Women	Men
Spouse	68	46	87	45
Lover	1	2	7	18
Boy/girlfriend	9	16	3	16
Sex worker	0	2	0	8
Friend	18	29	3	12
Other*	4	5	0	1
Total : Percent	100	100	100	100
Number	214	185	205	224

* Includes co-workers and neighbors.

The type of relationship and sex of the participant influenced the likelihood of involving sexual contact. Whereas spousal relations included sexual intercourse for all men and women, as is to be expected, the intimate ties of male participants had a higher proportion of sexual contact across all other forms of relationships. For example, 60% and 100% of boy/girlfriend relationships reported by participants involved sexual intercourse in Ranong and Chiangmai men, respectively.

A total of six percent of the participants noted having more than one sexual or intimate relationship in the past year. Significant differences were apparent across gender and study sites. Of those who had more than one sexual partner, women in both Ranong and Chiangmai shared about the same proportion, 2% and 3% respectively. However, 19% of the men in Chiangmai had more than one sexual and intimate partner, compared to 3% of their counterparts in Ranong (Table 7.4). This finding bore out the concern by the female migrants in Chiangmai that their current partners were maintaining multiple relations.

Table 7.4: Percentage Distribution of Participants According to Sexual Relations within the Last Year*

Relational Type	Ranong		Chiangmai		Both
	Women	Men	Women	Men	Sites
Never had sex	25	25	10	13	18
No sexual partner	2	17	-**	1	5
Had only one partner	69	51	81	58	65
More than one partner	2	3	3	19	6
Do not know/No answer	4	4	6	9	4
Total: Percent	100	100	100	100	100
Number	210	208	218	194	827

* Prior to being interviewed.

** Less than 0.5 percent.

I have had sex only with my two husbands and no one else. My first husband took a minor wife and we divorced. My present husband also had a minor wife at one time and had gone to live with her for six months after which he came back to me and our parents married us again, saying that we already had children together and, of course, he had to separate from his minor wife. My husband has had sex with many women other than me and his minor wife. I don't know what they used. As for me, I have never used anything.
Shan woman, age 32, construction worker in Chiangmai

Men usually go away to find more pleasure in sexual indulgence, but sooner or later, having learnt some hard lessons, they come back to their major wives. As our Shan saying goes, 'Divorce your major wife, and your [money] bag string will be broken.'
Shan woman, age 40, construction worker in Chiangmai

There were subtle clues throughout the discussions at each site that certain sexual norms are beginning to change. Although the data collected here does not look at sexual norms over time, changes in lifestyle, exposure to urban life, and migration out of tight social networks appears to have brought change in sexual attitudes, particularly among women.

These days many people are having sex outside of marriage. For some it is because of a shortage of money.
Burman woman, age 33, farm worker in Ranong

Girls in this country [Thailand] can't be controlled once they have a boyfriend. They're beyond control. So, it's up to the girls to exercise self-control. The boys they are free, so they can naturally have sex.
Tavoyan woman, age 43, farm worker in Ranong
Being a virgin is not so important in present times. Those who arrive to Thailand say they're

a virgin, but no one believes them. People don't trust anymore once they are here in Thailand.
Tavoyan man, age 22, sawmill worker in Ranong

There's decency and honesty in Burma, but in Thailand this is lacking. Women stay with any old person. Their parents aren't here and there is no discipline. Men as well as women lack discipline in Thailand.
Tavoyan woman, age 28, farm worker in Ranong

The life here in Thailand is different, particularly for women. In Burma they are safe because they are living under the control of their parents. But, here there are no parents. With so much freedom anything can happen to women. It is different than for men.
Burman woman, age 20, plywood factory worker in Mahachai

There is more freedom in Thailand because they are living far form their parents. Here they are more spoiled than in Burma. Here they do whatever they like.
Burman woman, age 30, shrimp factory worker in Mahachai

Here there is freedom. We have no parents to control us, so we can do as we like. When there is no family or children here your mind is free. Then you are physically and mentally free. But, you have to control your mind. If you don't, you will just be blown away.
Karen woman, age 25, fish canning factory worker in Mahachai

7.2. Reproductive Health

Reproductive health issues were discussed during in-depth interviews, focus group discussions and in the survey. The data collected from the two studies offered insight to a wide-range of reproductive health issues and insight into the dynamics of these issues in relation to their sexuality, lives as migrants, perceived choices and decision making process.

7.2.1. Menstruation

The majority of female participants had no knowledge of menstruation until after their first experience, and also little or no access to information thereafter. Many of them relied on tradition beliefs and customs to adjust to these bodily changes.

When I was 16 years old my menstruation came. I just stayed in my room. I didn't tell anyone. The second time it came for seven days and I stayed in my room the entire time. The third time my mother knew and told me that if I wash my skirt and hit it three times on the doorstep, my menstruation would last for three days. I did and it was like magic. It has come for only three days ever since.
Shan woman, age 25, construction worker in Chiangmai

My elders warned me not to wash my hair during menstruation. They said if one washes her hair while menstruating in youth, she can get all kinds of diseases when she reaches old age.
Shan woman, age 27, construction worker in Chiangmai

Before I got my menstruation my mother told me I should try to stay clean and be careful how I sit and stand. She also told me if I wash my hair the blood will stop and I will become ill. That is all she said.
Mon woman, age 27, sawmill worker in Ranong

When I got my menstruation I was told not to eat sour foods. I was also told now that I cannot go around freely and must watch out for men.
Shan woman, age 21, construction worker in Chiangmai

When I started menstruating I was told every time I do I must not eat certain foods. I could not offer flowers to the Lord Buddha. I even had to keep away from the Buddha shrine near the house.
Burman woman, age 20, shrimp factory worker in Mahachai

In childhood I would put boys on equal footing at play. Now after I started menstruation I could no longer play with them. I had to behave like a lady. I could no longer be familiar with the boys as I had before.
Burman woman, age 26, sawmill worker in Ranong

When my menstruation didn't come, people said I was pregnant. I didn't know this until I was already pregnant.
Shan woman, age 19, construction worker in Chiangmai

I hit menopause at age 42. I am now 45, so I have had menopause for three years. I was very thin before, but now I have gotten very fat. I don't know what is happening.
Shan woman, age 45, construction worker in Chiangmai

7.2.2 Pregnancy, Delivery, and Post-Natal Care

Nearly 90% of all the survey participants reported problems during and after childbirth, which they considered to be a serious problem, with one third noting such problems as extremely serious (38% in Ranong and 28% in Chiangmai). Among the women who had children born in Thailand, almost all of those in Chiangmai (96%) relied on a local government hospital for delivery, whereas only one-third of the women in Ranong did so (Table 7.5). The majority of women in Ranong (48%) reported delivery at home, largely with the assistance of a traditional birth attendant.[42] In addition, Ranong participants reported greater access to a clinic[43] for post-natal care (24%) than the Chiangmai participants (7%).

42 The term "traditional birth attendant" is broadly used to refer to anyone perceived as having experience in birthing, whether such person has formal training or not. In many cases, the Shan participants reported that the traditional birth attendant had no formal training, but 'just knew how to do it.'

43 The Ranong clinic is run by an NGO that specifically provides health services for migrant in the area

Table 7.5: Percentage Distribution of Participants' Perceptions of Problems During and After Childbirth Delivery in Thailand

Problems During and After Childbirth Delivery	Ranong	Chiangmai	Both Sites
Perception:			
- Not serious	8	8	8
- Somewhat serious	20	41	31
- Serious	27	21	24
- Very serious	38	28	33
- Don't Know	7	2	4
Total : Percent	100	100	100
Number	411	402	813
Place of Delivery			
- Hospital	34	94	63
- Clinic	16	0	8
- Home with TBA*	46	6	27
- Home without TBA	2	0	1
- Other	2	0	1
Total : Percent	100	100	100
Number**	88	82	170
Place of Post-Natal Care:			
- Hospital	36	66	50
- Clinic	24	7	16
- Traditional healer	8	25	16
- At home	30	0	16
- Other	2	2	2
Total : Percent	100	100	100
Number***	67	56	123

* Traditional Birth Attendant.

** Among those who had children born in Thailand.

*** Among those seeking post-natal care.

Due to Ranong's proximity to Burma and the availability of border passes, migrants who were unable to access health services in Thailand could cross the border to seek care. In-depth interviews suggested that the type of health care chosen by pregnant women migrants in Ranong was influenced by access, or lack thereof, to services in a formal health care system, convenience of travel, ability, or lack thereof, to speak Thai, cost, and reliance on employer.

> *I was afraid. It was my first child. I didn't want to go to the Ranong hospital because I couldn't speak or understand Thai. So, I went back home.*
> Tavoyan woman, age 25, sawmill worker in Ranong

> *I haven't been to the hospital or clinic yet. I haven't been anywhere yet. My neighbor urges me to have the child in the hospital here, but I don't have a health card. So, I will think about what is best to do. I can always go home.*
> Tavoyan woman, age 31, turtle farm worker in Ranong

> *My wife gave birth in our shack. I couldn't take her to the hospital. Luckily some of her friends knew what to do and everything was all right.*
> Mon man, age 27, farm worker in Ranong

One of the key informants in Ranong was a Burmese midwife who over a period of five years had assisted over 200 childbirths. With a shared language and culture, many migrants preferred midwives to the formal health care system, which was managed by Thai nationals (although some clinics did provide a translator). Cost was another important factor. Hospitals and clinics in Ranong often charge between 3,000-5,000 baht to deliver a child, whereas a midwife's usually chares 1,000 baht or under, and also allows for payment by installments if the full amount cannot be paid up front.

Some migrants, such as those working on plantations in Ranong, lived in remote areas and had difficulty accessing any form of services without the help of their employer. The employers, therefore, played a critical role for selecting the type of provider that a woman would see for childbirth delivery.

In Chiangmai, on the other hand, participants primarily chose to go to hospitals or clinics to deliver their children. The factors influencing this decision were convenience of travel (Chiangmai being an urban area, public transportation was readily available), a greater ability to speak some Thai, and the limited availability of traditional birth attendants.

> *I did not know what happened. People said that if my period stopped coming it was because I was pregnant. After a month I often felt dizzy and vomited, but that was gone after 3-4 months, so I worked as usual until the day the baby was due. I delivered her at a local Thai hospital. Our employer took me there and the fee was over 800 baht. We did not get a birth certificate. We dared not go and ask for it because we did not have any ID cards. We heard people say that they [Thai hospital] do not give birth certificates if the parents do not have citizen ID cards.*
> Shan woman, age 19, construction worker in Chiangmai

I was about 4 months pregnant at the time, when blood started to flow out (from the womb). A 'gay' man felt sympathetic and hailed a car for me to take me to Hang Dong hospital. I passed out 3 or 4 times on the way. Hang Dong hospital could not help so they transferred me to Suan Dok hospital where I was treated for 2 days. That cost 4,000 baht. After that I was sent back to Hang Dong hospital and they put a needle in my flesh on the inner-side of my left arm.
Shan woman, age 24, construction worker in Chiangmai

According to in-depth interviews and focus group discussions, migrant women both in Ranong and Chiangmai said that when they were in Burma, for the most part, they delivered their children at home with assistance from their husbands or traditional birth attendants. This was especially true for participants interviewed in Chiangmai, as there are limited or no medical services available in Shan State.

My three children were all born at my home in Shan State. A midwife helped to deliver the first two and my husband helped with the last one. I washed the hands of the midwife after the birth, as is our tradition. I bathed in traditional medicine during the one month after giving birth. I also bound my waist and took Shan medicine.
Shan woman, age 40, construction worker in Chiangmai

My husband delivered all three of our children at our home in Shan State.
Shan woman, age 33, construction worker in Chiangmai

Our two children were born in our village in Shan State with the help of my husband. I bore them and afterwards I took and bathed in traditional medicine.
Shan woman, age 45, construction worker in Chiangmai

The majority of Mahachai participants interviewed also reported delivering at home both in Burma and in Thailand, either with partners, friends, or a traditional birth attendant.

I have never been to a hospital. I just delivered all my babies at home with the mid-wife. I usually take only Burmese medicine, not western medicine.
Mon woman, age 38, factory worker in Mahachai

I had to help another woman deliver her baby here in Mahachai. She was an old woman and I had to give her a vitamin injection because she could not deliver. Then I had to give her a drip and an injection to open the womb. She could not afford to go to the hospital and just relied on me.
Burman woman, age 37, informal health provider in Mahachai

Now I have nearly a full term pregnancy. I don't understand any Thai. I want to deliver my baby with a Burmese midwife, but I don't know if they are available here. If not, can I ask you to help me deliver with your assistance to communicate to the doctor?
Burman woman, age 30, shrimp factory worker in Mahachai

Only a handful of women reported seeking medical services in Thailand before or after giving birth, either for themselves or their newborn, with the majority following traditional beliefs and self-care approaches. This study did not explore pre- and post-natal care issues in any depth, though such issues seem critical given the high mortality rate reported during in-depth interviews and focus group discussions.

My child was six months old. She got sick with a high temperature and died a few days later.
Shan woman, age 27, construction worker in Chiangmai

I gave birth to two children and unfortunately both of them died a few weeks after their birth.
Shan woman, age 25, construction worker in Chiangmai

The woman next door to me at the construction site was pregnant. She had no money and dared not go to the hospital. With the help of her husband they tried to deliver the baby in their room. But there were complications. It was nearly midnight and the husband tried to go to get help. When he came back his wife was almost unconscious. She delivered the baby in the car on the way and she died before reaching the hospital. It was a baby girl and was adopted by one of the nurses at the hospital with the father's consent.
Shan woman, age 40, construction worker in Chiangmai

7.2.3. Contraceptive Knowledge and Use

Participants at all three sites reported little or no knowledge or access to contraceptives while in Burma.

In Shan State we hadn't heard about contraceptives or sterilization. The more sex you had the more children. Some couples had 15 or 16 children. When we came to Thailand we asked people to tell us about contraceptives.
Shan woman, age 25, construction worker in Chiangmai

In Shan State injections from China were the only way to prevent pregnancy. I took them, but they didn't work. I got pregnant again.
Shan woman, age 32, construction worker in Chiangmai

I got an injection in my womb and they said it would prevent pregnancy. I did this four times, but it didn't work. I got pregnant again. My sister thinks maybe the medicine had expired.
Shan woman, age 35, construction worker in Chiangmai

I received contraceptive injections for six months. We lived together with Lahu and Akha in the village and one of them was a medic and gave me the injection.
Shan woman, age 25, construction worker in Chiangmai

Throughout the study, migrants reported a significant increase in access to and use of contraceptives in Thailand, as compared to Burma. Oral and injectible contraceptives were the most common form of birth control used (Table 7.6). The proportion of Chiangmai's participants who used oral contraceptives (45%) was nearly two times higher that of Ranong (24%). The majority of migrants purchased these products either from mobile markets[44] or over-the-counter drug stores (63% in Chiangmai and 58% in Ranong). Thirty-five percent of the participants in both Chiangmai and Ranong received oral contraceptives from a medical clinic or hospital. The proportion of those who had used or were using injectibles was a little over 30% for participants at both sites, who primarily obtained this birth control method from a hospital or clinic (72% in Ranong and 79% in Chiangmai).

Table 7.6: Percentage of Participants who Had Ever Heard of, Used, or were Interested in Modern Contraceptive Methods *

Contraceptive Methods	Ranong	Chiangmai	Both Sites
Oral Contraceptives			
% ever heard	89%	97%	93%
% ever used	*24%*	*45%*	*35%*
% interested	44%	76%	60%
Injectibles			
% ever heard	87%	98%	92%
% ever used	*32%*	*31%*	*31%*
% interested	51%	71%	60%
IUDs			
% ever heard	48%	71%	59%
% ever used	*1%*	*2%*	*2%*
% interested	27%	27%	27%
Norplant			
% ever heard	53%	74%	66%
% ever used	*9%*	*2%*	*5%*
% interested	34%	27%	31%
Condom			
% ever heard	86%	95%	91%
% ever used	*13%*	*16%*	*14%*
% interested	29%	51%	40%
Sterilization			
% ever heard	94%	82%	88%
% ever used	*6%*	*7%*	*7%*
% interested	41%	35%	38%
Number	418	409	827

* Wanted to learn or get more information about this method.

44 Mobile markets refer to pick-up trucks loaded with food and a wide range of other household items, including drugs for sale to migrant workers.

Most people take pills or injectibles for contraception. It is easy to buy the pills at any drug store.
Burman man, age 20, laborer in a shrimp transport company in Mahachai

The pill is cheap and easy to get. We can buy it right here at the market or any Thai drug store.
Shan man, age 26, construction worker in Chiangmai

We buy the injection medicine at the drug store and then ask somebody we know to inject it for us.
Burman woman, age 33, farm worker in Ranong

Every three months I buy the injection drug myself. Then the child's father [my husband] gives me the injections.
Tavoyan woman, age 43, farm worker in Ranong

Participants also used condoms, but to a much lesser extent than other forms of birth control (16% in Chiangmai and 13% in Ranong). Sterilization was also an option for some (7% in Chiangmai and 6% in Ranong). Condoms were primarily used only since first arriving in Thailand (especially among Chiangmai participants), while sterilization was a method most often used in Burma. In addition, a significant number of Ranong participants (9%) had used or were using Norplant as their birth control method (as compared to 2% in Chiangmai). The participants at both sites reported that in Thailand they themselves, or their partner, or the two together made decisions regarding birth control methods. Only among Norplant users were health providers identified more often as the decision-makers. Factors that influenced decisions regarding birth control were accessibility, legal status, and Thai language skills.

I decided not to have more children while I was in Thailand. I went to the district dispensary along the border and they gave me contraceptive pills. I was worried that I would forget to take them as required and heard about other methods of contraceptives. So, I went again and this time they buried six needles in my arm and told me that it would last for five to six years. I needed to come back in five years or if anything is wrong before then. It is more than a year now and I sometimes feel dizzy or get headaches, but I didn't go for a check-up yet.
Shan woman, age 32, construction worker in Chiangmai

In Shan State we never used contraceptives. But now in Thailand, I have buried six needles in my arm for five years. So far I have had no problems. The people at the government hospital who gave me the needles said that I can go to any doctor when I return home and have them taken them out.
Shan woman, age 40, construction worker in Chiangmai

After I recovered from my abortion, the hospital put needles in my inner left arm. They instructed me to come back for a checkup after five or six years. After eleven days the bandage came loose and the needle was protruding a little. I don't know what to do. Also, since that

injection I feel I have become quite short-tempered and impatient, sometimes like an insane person.
Shan woman, age 34, construction worker in Chiangmai

Sixty percent of all participants requested more information on birth control methods, especially oral contraceptives (76% in Chiangmai and 44% in Ranong) and injectibles (71% in Chiangmai and 51% in Ranong). A significant number of participants also requested more information on condoms (51% in Chiangmai and 29% in Ranong). They also expressed interest in learning more about non-contraceptive approaches, such as the rhythm method, turning the uterus, and herbal medicines to prevent pregnancy. Overall, participants in Ranong as compared to Chiangmai, were less interested in receiving information on various forms of birth control. According to key informants and observations from the researchers, this is likely attributable to social norms that induce embarrassment when discussing these issues, or even expressing interest in them. It should also be noted that most information available on birth control methods is in written form and not accessible to the largely illiterate migrant community.

My wife asked someone to buy pills for her. There are also injections but because we do not have identification cards and do not speak the language well, we are afraid to go.
Shan man, age 29, construction worker in Chiangmai

My wife takes pills every day. She often complains of itching and headaches. I have no idea what is wrong and no one among us knows anything about the medicine. I myself do not speak Thai. It is so frustrating.
Shan man, age 44, construction worker in Chiangmai

Ranong participants also relied on other non-contraceptive forms of birth control, such as withdrawal (22%), the rhythm method (25%), and herbal medicine (16%). The majority of the participants used these methods while in Burma, though the withdrawal method was still commonly used in Thailand.[45] However, among all in-depth interviews, only one person could explain the rhythm method (calendar cycle) correctly. In addition, there was a common mis understanding at all three sites that the days before and after menstruation were times of fertility.

Women can get pregnant seven days before and after her menstruation. If one does not want pregnancy, one should choose any time outside that period to have sex.
Shan woman, age 37, construction worker in Chiangmai

When she has menstruation we have to avoid seven days before and after. If we don't avoid it in these dangerous days, she can get pregnant.
Burman woman, 29 year old factory worker in Mahachai

45 This was also true among the Mahachai participants.

The study did not look at contraceptive effectiveness, but it did examine side effects of contraceptive use, although few side effects were reported other than weight loss or gain. The in-depth interviews and focus group discussions, together with researchers' observations revealed that the majority of migrants lacked a basic understanding of the use and possible side effects of most forms of contraceptives.

After I gave birth I received a contraceptive injection for six months. I don't know any more than that.
Shan woman, age 34, construction worker in Chiangmai

I have no plan to have more children. I go to visit my husband sometimes and I take pills if I sleep with him. I don't take pills if I don't sleep with him.
Mon woman, age 36, factory worker in Mahachai

My wife does not want a baby and she persuades me to use a condom, but I don't know what it is. I only have heard of it and have never actually seen one.
Shan man, age 34, construction worker in Chiangmai

My husband told me that by taking the pills I would have a very painful delivery in the future. I think he lied to me just because he doesn't want me to take them. So he scared me and I don't take anything as a result.
Burman woman, age 32, sawmill worker in Ranong

I have seen it with my own eyes. Some women who have used contraceptive injections had difficulties giving birth and had to go to the hospital. This is because their uterus shrunk.
Tavoyan woman, age 31, turtle farm worker in Ranong

7.2.4 Condom Use

Migrant workers' perception and knowledge of condoms, for the most part, was limited to an understanding that condoms were primarily used in commercial sex encounters and not within marital or other forms of stable relationships. Gender, in particular, influenced attitudes towards condom use. While 88% of women and 94% of men had heard of condoms, only 3% of women and 35% of men had ever used them (Table 7.7). Based on in-depth interviews and focus group discussions, participants explained that although they were familiar with the word "condom", they had never actually seen one or knew how to use one.

My wife does not want a baby and she tries to persuade me to use a condom. But I have only heard of it since coming to Thailand and have never seen one. I don't actually know what a condom is or how to use it.
Shan man, age 34, construction worker in Chiangmai

I have only seen condoms in Thailand when people pass them out. I don't know how or why we need to use them.
Shan woman, age 28, construction worker in Chiangmai

Once a Thai delivery boy had one and I asked him what it was. He gave it to me and said it was a balloon. I tried to blow it up. He told me I was crazy that it was actually a condom. That is all I know. A condom is like a balloon.
Mon woman, age 27, vendor at the market in Mahachai

Condom use among the participants who had been sexually active varied greatly between men and women and between the Ranong and Chiangmai sites. As expected, men had more experience with condoms than women. Ranong women, however, were more likely than their counterparts in Chiangmai to have ever used condoms (Table 7.7).

Table 7.7: Percentage of Participants who ever Heard of or Used Condoms

Ever Heard of or Used Condoms	Ranong		Chiangmai		Both Places	
	Women	Men	Women	Men	Women	Men
% Ever heard of comdoms	82%	91%	94%	96%	88%	94%
(N)	(210)	(208)	(218)	(191)	(428)	(399)
% Ever used condoms among those sexually active	5%	34%	2%	35%	3%	35%
(N)	(129)	(119)	(180)	(155)	(309)	(274)

The type of relationship, as demonstrated by Table 7.8 below, greatly influenced condom use. This was particularly true for men. Women reported relatively fewer types of relationships, other than spousal relations, that contained sexual contact.

Table 7.8: Number and Percentage of Condom Use According to Relational Type (Women)

Relational Type	Ranong Women				Chiangmai Women			
	Never	Some times	Always	No response	Never	Some times	Always	No response
Spouse	(93%) 138	(6%) 9		(1%) 2	(97%) 174			(3%) 5
Lover	(100%) 1				(91%) 10			(9%) 1
Boyfriend	(50%) 2	(25%) 1	(25%) 1		(100%) 1			
Friend	(100%) 1							

The association between type of relationship and condom use was clearer among men, who expressed many more types of sexual relationships than did women. As Table 7.9 illustrates, Ranong men never used condoms in 87% of their spousal relations or 82% of their other romantic ties (lover, minor partner, girlfriend/friend). Chiangmai men revealed a similar pattern, never having used condoms with 95% of spousal ties and 87% of other romantic ties. The majority of the commercial sex ties among Chiangmai men (94%), however, involved condom use as compared to 75% in Ranong.

Of the 113 male participants who had procured sexual services, 70% responded that they had always used condoms, whereas 14% had never used one. There were significant differences, however, between men in Ranong and Chiangmai. Condom use during commercial sex encounters was more common in Chiangmai. The proportion of those who always utilized condoms was as high as 91% among Chiangmai men but only 43% among Ranong men. Twenty-nine percent (29%) of Ranong men who had frequented sex workers had never used a condom, compared to 3% of Chiangmai men (Table 7.9)

Table 7.9: Number and Percentage of Condom Use According to Relational Type (Men)

Relational Type	Ranong Men				Chiangmai Men			
	Never	Some times	Always	No response	Never	Some times	Always	No response
Spouse	(87%) 76	(11%) 10		(2%) 2	(95%) 100	(1%) 1		(4%) 2
Lover	(100%) 3				(88%) 29	(12%) 4		
Girlfriend	(94%) 17	(6%) 1			(87%) 33	(10%) 4	(3%) 1	
Sex worker	(29%) 14	(25%) 12	(42%) 20	(4%) 2	(3%) 2	(6%) 4	(91%) 59	(2%) 2
Friend	(75%) 3	(25%) 1			(83%) 5	(17%) 1		

The participants' attitudes toward condoms were formed mostly from what was heard from spouses, friends, or the mass media. Although condom use as a form of contraception was known among the migrants, the prevailing attitude was that condoms primarily served as protection against infections. The participants who had become familiar with condoms did so in the context of AIDS prevention. Infections being highly associated with sex workers, meant that participants felt little need for condom use in stable or marital relationships. Moreover, according to social norms, condom use represented mistrust and promiscuity, but equally important, not using a condom symbolized trust and emotional intimacy and loyalty to one's partner.

Married couples don't use condoms.
Shan woman, age 20, construction worker in Chiangmai
I would be insulted if my husband asked me to use a condom.
Shan woman, age 22, construction worker in Chiangmai

I am too embarrassed to talk about condoms to my husband. I have no idea really. It doesn't concern me, so I don't even think about it. My husband and I don't need condoms in our relationship. Men use them only when they go fooling around.
Tavoyan woman, age 33, sawmill worker in Ranong

The condom is used in bad places. From what I hear, when men go to brothels they use the condom, so they don't contract diseases from the women. If they use it, it can prevent the disease. Some men use it when they make love to their wives because they used to go to bad women. My husband and I don't use it. I know his character and he knows me very well.
Tavoyan woman, age 42, sawmill worker in Ranong

Our relationship is monogamous. There's no drinking or carousing. We're just monogamous. We don't have a complicated relationship. You can see that he's a simple man, over 40 years old.
Tavoyan woman, age 37, sawmill worker in Ranong

Condoms can protect us from any disease, but only people who are no good and go to brothels use them. If a man uses a condom, women will think he is no good.
Burman woman, age 24, unemployed in Mahachai

There are girls who are good and not good. When we have sex with bad girls we use a condom. It protects us from AIDS.
Indian man, age 24, porter for a shrimp factory in Mahachai

Approximately two thirds of both men and women in Ranong stated that they would have a strong negative reaction if their partner requested them to use a condom (Table 7.10). This was not the case in Chiangmai where a higher proportion of women than men ($p < .01$) had negative reactions towards condom use, though to a lesser extent than their counterparts in Ranong. The Chiangmai women also identified condoms predominantly as a birth control method, unlike their Ranong counterparts.

Table 7.10: Attitudes Towards Condom Use

Attitudes	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Negative*	61	66	64	33	25	29
Indifferent**	11	10	11	1	9	5
Positive***	7	9	8	23	27	25
Don't Know	21	14	18	43	39	41
Total : Percent	100	100	100	100	100	100
Number	210	218	418	217	191	407

* Included strong negative (angry, offended) to somewhat negative reactions.

** No reaction.

*** Included strong positive (protected, secure) to somewhat positive reactions.

Reactions to condom use by men in Ranong and Chiangmai ranged from a lack of comfort and sensitivity to a belief that condoms were only needed in commercial sex relations. The majority of men at both sites felt that having a stable/steady partner made it unnecessary to use condoms.

I haven't seen it ... only heard of it. Men who go to brothels know it. Since I don't go, I don't know.
Karen man, age 38, farm worker in Ranong

Condoms are for men to put over their penises, and those who use them would say that they feel quite natural and the touch of them is not different from the real skin. But those who do not like them would have many complaints, they would say that it is annoying and touching with a stick is not like touching with the hand.
Shan man, age 48, construction worker in Chiangmai

I have not used any condoms. I do not like the feel of them. I know where it is supposed to be used, with whom, and what happens when used, such as preventing pregnancy and protecting from contracting AIDS. I understand all that.
Shan man, age 21, construction worker in Chiangmai

I have seen men who go to prostitutes use them. For a woman, it is not good. When having sex, she would not experience the touching of two bodies if a condom was used.
Burman man, age 25, farm worker in Ranong

Women reacted more negatively to condoms than did men. A strong association with commercial sex workers further entrenched a deep cultural division between 'good' and 'bad' girls, a dominant sexual norm in the Burmese culture. Such sexual norms serve as a mechanism for maintaining 'proper' sexual conduct and controlling the sexual and social behaviors of women. One focus group discussion, in particular, highlighted the nature of women's aversion toward condoms.

3,2: I wouldn't want my husband to use a condom.
A: Why wouldn't you find it acceptable?
5: After all I'm not a prostitute. Why should I accept it.
1: My husband wouldn't do that. After all, he'd acknowledge me and the children as wife and family and relate to us as such. I'm not a prostitute. It (condoms) wouldn't be acceptable at all.
4: He better not even mention the word FY (condom).
7: I'd kill him if he used FY. I'll take responsibility.
4: Yes, but you wouldn't know where he'd get it from or what he'd do with it. If he puts it on himself, it's not as though you'd know.
5: If he wore it before my own eyes, then I wouldn't accept it.

2: Sure.

5: If they want to wear it, then they can get out. Just go to prostitutes. I've worked in shops too. That business is no good.

Based on the survey data, participants' reactions to a partner's request to use a condom were significantly different across gender and study sites. In Chiangmai, men were about 1.9 times as likely as women to accept condom use if their partner asked, whereas in Ranong there were no gender differences (Table 7.11). While, as is to be expected, the majority of people who felt positive emotions relative to condom requests were more likely to accept condom use, participants with strong negative feelings toward condoms did not necessarily refuse to use them. Nineteen percent (19%) of the women and 17% of the men who expressed strong negative feelings said they would allow a partner to use a condom if the partner asked.

Table 7.11: Percentage Distribution of Participants' Reactions to Partner's Request to Use a Condom

Reaction	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Accept	26	26	26	19	30	24
Refuse	54	58	56	42	32	37
Don't Know	20	16	18	39	38	38
Total : Percent	100	100	100	100	100	100
Number	210	218	418	217	191	407

Although many had knowledge of condoms for protecting against diseases, such as AIDS, they expressed a lack of interest in using them. Seventy-one percent (71%) of Ranong participants and 49% of those in Chiangmai expressed no interest at all in receiving information about condoms (see Table 7.6 above). This lack of interest may stem from a perceived negative image on those who show too much curiosity or knowledge about sex and related issues. In addition, while migrants may consider AIDS to be a serious problem for the community, they did not view themselves as susceptible to it and therefore did not consider it a priority for concern in their lives.

7.2.5 Abortion

Approximately 17% of the participants (99 out of 587) who had ever had unwanted pregnancies attempted abortions (Table 7.12). Among these, 55% reported having an unsuccessful or complications with the abortion. The place where abortions were performed differed significantly between the Chiangmai and Ranong participants. Seventy-two percent (72%) of

abortions among those in Chiangmai were performed in Burma, as compared to 35% in Ranong. In addition, 15% of Ranong's participants reported having had abortions at the border. This can probably be accounted for by the border sharing between the Thai province of Ranong and the town of Kawthuang in Burma, as well as the availability of border passes, as mentioned earlier.

One notable difference regarding abortions between the two sites was that among Ranong participants 55% of the abortions were self-induced, 25% were performed by a traditional birth attendant, and 5% by health personnel at a clinic or hospital. Whereas in Chiangmai, 60% of the participants relied on a traditional birth attendant, 28% on public or private health personnel, and 8% were self-induced.

Table 7.12: Percentage of Participants who Had Unwanted Pregnancies and Attempted to Obtain an Abortion

Unwanted Pregnancies	Ranong	Chiangmai	Both Sites
% attempted to obtain an abortion	20%	14%	17%
(N*)	(287)	(300)	(587)
% of successful abortions	34%	49%	45%
(N**)	(58)	(41)	(99)
Place where abortions were performed:			
- in Burma	35	72	55
- at border	15	0	7
- in Thailand	50	28	38
Total: Percent	100	100	100
Number	20	25	45
Who performed abortions:			
- Self-induced abortions	55	8	30
- Traditional birth attendent	25	60	44
- Health personnel	5	28	18
- Others***	15	4	8
Total : Percent	100	100	100
Number	20	25	45

* Number of participants themselves or their partners who had unwanted pregnancies.

** Number of participants who attempted to obtain an abortion.

*** Husband or friend.

Participants' discussion of self-induced abortions revealed that a number of different methods were frequently used, including massage of the uterus, traditional herbs and alcohol, sticks and rods, western injections or drugs, or some combination thereof. These methods were often not only ineffective, but also frequently resulted in severe health complications, including death.

There are roots, leaves, and stalks of trees that are mixed together and taken to induce abortion. People nowadays don't know these natural medicines and often take many pills from untrained doctors.
Shan woman, age 36, construction worker in Chiangmai

My mother gave me black liquid medicine that tasted cool and like alcohol, but I didn't know what it was. Than she massaged and pressed my womb, but I did not abort. Finally, I delivered a baby girl at the hospital in Shan State. The baby was healthy and normal.
Shan woman, age 29, construction worker in Chiangmai

A friend from my village massaged my stomach. It was easy to abort a pregnancy that way. I was bleeding a lot. I paid 300 kyat for each abortion.
Shan woman, age 21, construction worker in Chiangmai

I accompanied my friend to get an abortion. They induced the abortion by inserting a pipe into her. But the abortion did not happen immediately. After two or three days there was a lot of blood. Then she took the traditional medicine to stop the bleeding. She was still bleeding too much so I advised her to boil white-plum leaves and drink it. She recovered immediately after that.
Tavoyan woman, age 20, sawmill worker in Ranong

I first tried to induce an abortion with an injection. But after five days I had no menstruation. So, I paid to go to a midwife. She used an iron rod to abort. I was afraid so I returned home and instead asked my husband to massage and step on my stomach. I also bought medicines that are very hot. But, I still didn't abort.
Tavoyan woman, age 42, old sawmill worker in Ranong

When I had an abortion a Mon woman inserted flat bamboo sticks into my uterus. Actually I didn't want to use sticks because I was afraid of cancer, but she assured me she wouldn't use them. Then she told me to lie down and inserted those bamboo sticks and poked only twice. There was a sudden discharge and then she said it was done. I was barely conscious when I left and still bleeding heavily. When I finally went to the hospital I had stopped bleeding and they gave me some vitamins and medicine to treat the damaged uterus. When I got home I started aborting the actual fetus.
Tavoyan woman, age 43, farm worker in Ranong

My neighbor at the construction site died while trying to abort her child. She had been trying for about three months to abort the baby. She drank a lot and told others to press and step on her stomach. Suddenly she became very full of pain, groaned, and cried. The baby aborted and she had a stroke or something. I wanted to take her to the hospital, but her husband would not allow me. He said his wife had a bad heart to kill her child, so she too should die.
Shan woman, age 22, construction worker in Chiangmai

Ever since I had my abortion my menstruation each month is so painful. I try to take Shan traditional medicine with hot water, but it doesn't help much. It is also hard to find it in Thailand.
Shan woman, age 34, construction worker in Chiangmai

First the traditional birth attendant inserted a ring to induce an abortion. Then she gave me an injection and some medicine to open the uterus. I suffered a lot and had high fevers and chills. Then people massaged me until my whole body was painful. Then I got foul smells from my mouth and finally went to the hospital. They operated immediately. It was very expensive, nearly 6,000 kyat.
Burman woman, age 30, shrimp factory worker in Mahachai

Males and females alike explained that the decision to abort was typically because a couple was not yet married, or already had too many children, or was not in a secure political or financial situation. Several noted that a lack of access to, and knowledge about and proper use of, contraceptives prompted many Burmese migrants to resort to abortions as a form of birth control.

Most people do not know anything about contraceptives, if they do not want the already conceived child they just get an abortion by massage. They do not know if it is against the law or not, and they do not care, it has nothing to do with them.
Shan man, age 26, construction worker in Chiangmai

After giving birth to my first son, I had three abortions while in Shan State. After the abortions, I had my youngest son. I could not afford to have a big family.
Shan woman, age 21, construction worker in Chiangmai

After about a month, my boyfriend had to go back to the frontline. He died in battle and I was left alone and pregnant. We didn't even get a chance to marry. I was afraid that the others would find out about my pregnancy, so I had an abortion. I found a woman to massage my stomach.
Shan woman, age 25, vendor at a construction site in Chiangmai

My daughter was just eight months old and I was four months pregnant again. It was too much so I sought an abortion.
Burman woman, age 30, shrimp factory worker in Mahachai

If women get pregnant here the employers do not allow them to work. It is a big problem as many people come here to work only for a short time. So, almost all of the women want to get an abortion. They ask me to help them because they know I am a nurse. I said I can only give them an injection if it is less than one month. After that I cannot help. If they are pregnant more than one month they go to a nurse in another place who will do an abortion for 3,000 to 5,000 baht. But, she says she will not take any responsibility for any complications. Some women are bleeding or still have parts of the placenta left inside and are very sick afterwards.
Burman woman, age 37, informal health provider in Mahachai

The majority of participants, including women who had undergone abortions, knew they were illegal (both in Burma and Thailand), dangerous, and contravened religious teachings.

I wanted an abortion, but I heard that if the police know they will lock you up. Also, we didn't have enough money. That is why we just keep having babies one after another.
Shan woman, age 30, construction worker in Chiangmai

According to Buddhist law it is a big sin to get an abortion.
Mon woman, age 22, farm worker in Ranong

The girl is to blame for having an abortion because she indulged the boy who couldn't resist. If she behaved properly, nothing would have happened.
Tavoyan woman, age 37, sawmill worker in Ranong

If you get an abortion, you are half way to the cemetery. I don't agree because it is just too risky.
Garuka woman, age 25, dorm leader in Mahachai

For many women, however, abortion was the only way to deal with their immediate situation.

I do not encourage abortions. But, when they come to see me they are often desperate and I try to help. I either give injections and if that doesn't work then massages. It is very dangerous. I have witnessed so many complications and many women have had to go to the hospital.
Burman woman, age 37, informal health provider in Mahachai

I don't accept abortions, but after I got pregnant I had no choice. I am afraid of my life and my babies.
Burman woman, age 20, plywood factory worker in Mahachai

7.2.6. Reproductive Tract Infections

Participants during the in-depth interviews and focus group discussions were unable to clearly identify or describe types of or symptoms of reproductive tract infections. Moreover, there were few words in their language or vocabulary that could describe or distinguish

between various reproductive tract infections and other illnesses (including women's normal monthly discharges). This was particularly true among the Shan participants. The lack of vocabulary made it difficult to ask questions regarding reproductive tract infections, as separate from HIV/AIDS. In attempting to describe symptoms, participants often relied on certain cultural assumptions about health and disease. For example, discharge was assumed to result from physical weakness.

> *I have had white discharge for over a year now. I get it just one day before my menstruation. When I have it I feel very tired. It seems I have gotten thinner since I have had the discharge. I don't know what is happening to me.*
> Shan woman, age 34, construction worker in Chiangmai

> *I got sick with white discharge when I worked with cane and had to sit for a whole day. I took rice water mixed with Burmese medicines. Sometimes I also took the leaf of a Zephu and put it on the chair I sat on. My sister got the burning in her urination from eating a lot of chili and hot stuff. She went to a doctor in Burma who deals only with virgins and treats with traditional medicines.*
> Burman woman, age 20, shrimp factory worker in Mahachai

> *White discharge is caused by weakness. When I get it I go to the clinic. They give me an injection and pills.*
> Tavoyan woman, age 25, sawmill worker in Ranong

Most survey participants considered symptoms of discharge, often with a strong smell or itchiness, to be a somewhat serious to very serious problem (Table 7.13). As noted earlier, there was a limited language available to describe specific symptoms and reproductive tract infections. Thus, the following data is not a representation of infections but rather of gynological problems perceived by migrant females. In Chiangmai, thirty-three percent (33%) of the female participants had experienced such symptoms, as compared to 12% in Ranong. Among the female participants who responded to these symptoms, 45% in Chiangmai purchased remedies at the drugstore compared to 31% in Ranong who sought interventions from traditional healers. Others reported seeking treatment from a clinic (approximately 15% at both sites). Nearly half of the participants in Ranong did not seek any treatment whatsoever (47%).

Table 7.13: Percentage Distribution of Participants who Reported Problems of Discharge

Problem of Discharge	Ranong	Chiangmai	Both Sites
% experienced discharge	33 %	12 %	21 %
(N*)	(301)	(384)	(685)
Perception:			
- Not serious	26	14	20
- Somewhat serious	22	59	40
- Serious	20	17	19
- Very serious	11	10	10
- Don't Know	21	1	11
Total : Percent	100	100	100
Number	412	404	816
Place of Treatment:			
- Hospital	2	7	3
- Clinic	16	11	15
- Drug store	3	45	16
- Traditional healer	31	21	28
- Other	0	16	5
- No treatment	47	0	33
Total : Percent	100	100	100
Number	99	44	143

* Among those who answered the question.

** Among those who experienced malodorous discharge.

The causes of and remedies for discharge, what the participants sometimes referred to as 'white blood', differed widely among the participants.

I have white blood about three days before my menstruation. It is light yellow, smells of decay and is itchy.
Shan woman, age 22, construction worker in Chiangmai

I always have discharge and pains when urinating. I don't do anything. I take novalgin [analesgesic] when I have my menstruation, about three pills. I don't go to the clinic. I am very afraid of it.
Mon woman, age 27, sawmill worker in Ranong

I have discharge when I sit too long. I don't go to get treatment. I just take an anti-muscular medicine to ease the stiffness. I feel a little bit better afterwards.
Burman woman, age 30, shrimp factory worker in Mahachai

Some people come to me when they have white discharge. I give them injections and pills. I also try to explain to them that people can get white discharge if they are not clean.
Burman woman, age 37, informal health provider in Mahachai

If you get tired you get white discharge and can only be healed by Burmese medicine.
General consensus among at a focus group discussion in Mahachai

I just know that my wife gets white discharge sometimes, but I don't know why or what to do.
Burman man, age 20, laborer for shrimp transportation in Mahachai

Participants were also asked about difficulty urinating, with 97% of all participants having heard of this problem in relation to sexually transmitted diseases. In Chiangmai, 14% had experienced it compared to 46% in Ranong (Table 7.14). Participants at both sites turned most often to traditional healers for remedy (23% in Ranong and 35% in Chiangmai), with clinics and hospitals as the second major outlet for care (Ranong 25% and Chiangmai 33%). One-fifth of all participants treated themselves by purchasing medicine from local drug stores. In Ranong, as was the case earlier, a considerable number of participants chose not to seek any treatment (33%).

Table 7.14: Percentage of Participants who Experienced Difficulty Urinating

Problem with Difficulty Urinating	Ranong	Chiangmai	Both Sites
% experienced difficulty urinating	46%	14%	30%
(N*)	(301)	(384)	(790)
Perception:			
- Not serious	17	6	12
- Somewhat serious	33	63	48
- Serious	30	21	26
- Very serious	13	8	10
- Don't Know	7	1	4
Total : Percent	100	100	100
Number	411	404	815
Place of Treatment:			
- Hospital	4	24	9
- Clinic	21	9	18
- Drug store	17	28	20
- Traditional healer	23	35	26
- Other	2	4	2
- No treatment	33	0	25
Total : Percent	100	100	100
Number	180	54	234

* Among those who answered the question.

** Among those who experienced difficulty urinating.

For men, the most common disorder is difficulty and pain when urinating. It is as if s omething is blocking the way. It happened to me once. I did not know what medicine to take and my mother gathered some herb and boiled it for me to drink. I also went to the traditional healer who gave me a kind of holy water to drink. After some time I was cured.
Shan man, age 48, construction worker in Chiangmai

I suffered from urinary disease just last week. Whenever I urinate it feels hot and painful. The color of the urine is dark yellow. I am taking effervescent water as told to me by my grandmother.
Tavoyan man, age 18, farm worker in Ranong

I have trouble urinating and burning around my genitals just before my menstruation. I buy some traditional Thai medicine and take it.
Burman man, age 20, plywood factory worker in Mahachai

This is a big problem for men who work on fishing trawlers. They come to dock for a few days and go to prostitutes. Then after a few days when they are back at sea they get symptoms of disease, but there is no medicine at sea. If they could treat it immediately they would be fine but sometimes they are not back to shore for five months. They like to treat themselves because they are shy of the female nurses and doctors. But, some men have such terrible problems and are not easily treated.
Mon man, age 23, laborer in Mahachai

For me when I get these kinds of problems I just discuss it with people around me. I feel too shy to go to the hospital. My friends might say you should do this and you will be fine. Or another friend would say something, so I know about this traditional medicine. I don't want an injection. Some people say that if I spit on it [penis] with beetle nut juice it'll be fine.
Indian man, age 24, porter for a shrimp factory in Mahachai

7.2.7 HIV/AIDS

While almost all of the survey participants had heard of AIDS (98%), only 60% were able to correctly answer questions about HIV transmission routes. The majority of them were aware of the risk of contracting HIV through blood transfusion (93%), sharing needles (92%), and tattooing (75%), but misinformation was still prevalent. Over half of the participants believed that HIV could be transmitted by mosquitoes or through casual contact (such as hugging or working together). There were no gender differences between or within the two study sites (Table 7.15).

Table 7.15: Percentage of Correctly Answered Questions on HIV Transmission Routes

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Mean	59	61	60	60	62	61
Median	64	64	64	64	64	64
Std. Deviation	25	26	20	22	22	21
Number	208	203	215	215	191	406

One of the common patterns that emerged from the in-depth interviews and focus group discussions was the lack of understanding of the difference between HIV and AIDS. The majority of participants only discussed HIV infection in terms of the symptoms of AIDS. Attrition, skin rashes, and boils were identified as the symptoms of someone who had contracted the AIDS virus. No one mentioned the asymptotic signs of HIV infection. Most people felt that one should avoid contact with individuals who manifested any of the symptoms noted above in order to prevent HIV infection. It was also commonly believed that healthy-looking individuals could not possibly be infected with HIV. Participants were quick to judge boils, rashes, and other symptoms - such as difficulty urinating or sores on the genital areas (generally associated with sexually transmitted diseases) - as evidence of AIDS.

My friend started getting lumps and she didn't know what was happening. When she felt hot, she was always standing spread out in front of the fan, all red. She had clusters of blisters all around her lips too. Because of all the itching she was frequently having water poured over her. The disease was transmitted from her husband and is AIDS of course. There is nothing she can do.
Tavoyan woman, age 37, sawmill worker in Ranong

At first when I came to Chiangmai with my new husband, he started having a lot of skin rashes. He also used to smoke a lot. He had a liver disease and had to be hospitalized. At that time I was worried that he might have what they called AIDS. He had rashes all over him. If he had AIDS, I was thinking of leaving him. I only calmed down after the doctor said he had a liver disease.
Shan woman, age 32, construction worker in Chiangmai

I once suffered from having difficulty in urinating and I thought I had AIDS. But in fact I don't know what AIDS looks like, I've only heard a little about it from others. Most workers like us don't know very well what AIDS is like, and when people die of strange diseases they blame the evil spirits. They still believe like that.
Shan woman, age 34, construction worker in Chiangmai

AIDS continues to conjure fear and stigma for most of the migrant workers. The fear associated with HIV/AIDS is not only fear of contracting and suffering from the disease, but also fear of being stigmatized, discriminated against, and bringing shame to oneself and one's family.

I have heard that about six or seven people in my village have died from AIDS. They got it here in Thailand and they died back in the village. One man knew he had this disease. He became extremely thin. He had sores on his hands. They say that he would last only two days. A doctor came and gave him an injection. He died shortly after. His parents accused the doctor of killing him.
Mon woman, age 27, sawmill worker in Ranong

They said that someone from the house further down contracted it [AIDS]. There were sores on the body. When that happened, (the person) went to the hospital but was refused admission. They say that when that person went to the doctor, he was killed with an injection.
Tavoyan woman, age 34, farm worker in Ranong

I have seen a Shan woman with AIDS. She got it when she went to work in the gem mines along the China border. When she came back, her parents and relatives were afraid of her. They fed her as if she was a pig or dog. She was very thin and dry and her eyes sagged. I went often and talked to her. Now she is dead.
Shan woman, age 33, construction worker in Chiangmai

In our country, lepers and AIDS patients are kept in quarantine. This is usually a shelter built some distance outside of the village or town. Most people cannot distinguish between leprosy and AIDS.
Shan man, age 26, construction worker in Chiangmai

Condoms are very important. If men don't use them when visiting prostitutes they can easily get AIDS. Everybody knows what AIDS is, but for people like me, we don't know properly how to prevent it. If one gets AIDS it would affect their name and that of their parents and children. We should be careful. But it is hard to control when I am drunk.
Shan man, age 24, construction worker in Chiangmai

I think AIDS is a big problem. It's a shame for the relatives. People would ask, "Whose brother was that?" or "Whose sister was that?" and you'd feel inferior. No one even would want to touch you when you die with the disease in fear that they would catch it. Even the relatives won't touch you ... To prevent yourself, you must stay away from AIDS patients. For me I'll never get near them. I'm also afraid. I can't let myself be transmitted. If I get AIDS, I'd rather kill myself, yes, for me I won't humiliate my family and relatives.
Burman woman, age 33, farm worker in Ranong

In spite of the rumors, fear, and shame attached to AIDS, only a few participants during in-depth interviews (N=75) perceived themselves at risk of becoming HIV positive. Five women expressed that they might be susceptible because their husbands had frequented commercial sex establishments and three men admitted that they might have been exposed to HIV because of previous encounters with sex workers.

When working on a smuggling boat and because of bad influence there I went to brothels seven times. Some of my friends who have this kind of experience made me drink a lot. Because I was drunk I didn't know anything and I had sex. At first I used a condom. I used the condom twice. After that I stopped using it because it didn't feel good. I didn't get any feeling if I used a condom... the sex worker told me to use the condom; she put it on herself and also took it off. I didn't use it any more after the first two times. At that time I didn't know

much about AIDS.
Tavoyan man, age 18, farm worker in Ranong

Once I went after him [husband] to a brothel and when I saw his friend I quietly waited outside and he came out with a prostitute. I said to him that it was his money, but I was afraid of HIV, and one could get it by having sex just one to three times. The prostitute willingly accepted him and at one point he even went and stayed with her for three days.
Shan woman, age 25, construction worker in Chiangmai

Now many women are like men, they also cannot live without sex like us. We have to take the woman for a blood test if we dare to have sex. But I have never taken any blood test yet. I won't marry a girl so easily. I will wait and see whether she is a virgin or not. I'm afraid of AIDS. If we know them without knowing their past, we are like stupid cows.
Indian man, age 24, porter for a shrimp factory in Mahachai

I heard about AIDS on the Shan radio program in Thailand. It is quite dreadful and our young people should be very careful. It is contagious and everyone has a responsibility to prevent it.
Shan man, age 44, construction worker in Chiangmai

The reasons participants gave for why they did not perceive themselves at risk of contracting HIV/AIDS were that (i) they were in monogamous relationships, (ii) avoided commercial sex, (iii) had a spouse who was 'simple and trustworthy,' (iv) maintained cleanliness, and (v) obtained regular medical check-ups. Data from the in-depth interviews and focus group discussions strongly suggests that the majority of participants perceived AIDS as a disease confined to a risk group, in this case, sex workers, rather than to sexual behavior. Seventy percent of the survey participants believed that even with condom use HIV could be transmitted if one had sex with a prostitute. This association with a specific population group led the majority of the study participants to assume that prevention lay in avoiding any form of contact with sex workers, and it also fueled fear and discrimination in the migrant communities.

One is infected through prostitutes and through blood. As my husband lives only in our orchard and never goes anywhere, our family might have other diseases but never AIDS.
Mon woman, age 22, farm worker in Ranong

It's called 'hpaa yawga' (prostitute's disease). It's common among prostitutes. AIDS is contracted if men in Shan-Kan (Thailand) have sex with prostitutes. That's why I said I was scared. I always told my husband not to go near prostitutes when he used to come to Shan-Kan by himself. I would tell him that the germs will be transmitted to your wife and children. It doesn't stop with one person. So don't go near prostitutes.
Shan woman, age 32, construction worker in Chiangmai

There is no medication for that (AIDS). I mean the sort of medicine you take in advance before infection. After the disease is contracted, they say there is no cure either. If you exercise self-control and avoid contact with women of that sort, then you don't contract the disease. That's what people say.
Tavoyan woman, age 35, farm worker in Ranong

It transmits from bad women to good men. It will transmit if men sleep with other women and then sleep with their wives. They can even transmit it to their children. If a husband is unfaithful to his wife she and the baby could get it. It starts from the bad women.
Mon/Karen woman, age 28 year, fish canning factory worker in Mahachai

7.3. Concluding Remarks

Limited information and inability to openly discuss sexuality and reproductive health issues prevailed across all three sites. The extent of information and discussion on these topics varied according to gender and level of education. Male participants were more readily able to discuss these issues among themselves than were women. The participants who had received higher levels of formal education (largely Burmese from central Burma) had greater access to information on sexuality and reproductive health. The majority of female participants did not have this access and possessed little to no knowledge of such issues.

Different sexual norms between the sexes were evident, with strong values of virginity associated with girls and women. Loss of virginity for those not yet married often resulted in serious consequences. Boys and men, on the other hand, were considered by their nature to have a greater sexual drive and to be more sexually active prior to marriage. Commercial sex patronage by men was described as a common social event. Social norms were supportive of single men visiting sex workers, but it was less socially accepted for married men.

Sixteen percent (16%) of the women and 9% of the men believed their partners currently had other sexual partners. In addition, sexual attitudes showed signs of changing, particularly among women, as a result of exposure to urban life, and migration out of tight social networks.

Complications arising from childbirth delivery was considered a major health problem by nearly 90% of all survey participants. This was especially true among participants in Chiangmai. The majority of births among Ranong (and Mahachai participants), both in Burma and Thailand, took place at home, though more women went to hospitals to deliver in Thailand than in Burma.

Participants at all three sites reported little or no knowledge or access to contraceptives while in Burma, as well as increased use in Thailand. Oral and injectible contraceptives were the most commonly used form of birth control. The majority of contraceptive users purchased them from mobile markets or over-the-counter drug stores, while one third of the participants obtained their contraceptives from a medical clinic or hospital. All the participants were interested in obtaining more information on specific types of contraceptive methods and their side effects, particularly oral and injectible contraceptives.

Among participants who reported having an unwanted pregnancy, 17% attempted abortions, though only 45% were successful. Reasons given for seeking abortions were typically not yet married, too many children, and not in a secure political or financial situation to raise children. Women at all the sites reported serious side effects from abortions.

Participants throughout the study were unable to clearly identify or describe types of or symptoms of reproductive track infections. In addition, there were few words in their vocabulary that could define or distinguish between various forms of reproductive tract infections.

The vast majority of participants had heard of condoms (91%), but only 14% had ever used them. Men had more experience with condoms than women. Condoms were associated with sex workers and understood as important in the context of HIV/AIDS. Condoms generally represented mistrust and promiscuity, while not using a condom symbolized trust and loyalty to one's partner. Many women reacted negatively to condoms while men often did as well, but to a lesser extent. Although many had knowledge of condoms for protecting against diseases, such as AIDS, they expressed a lack of interest in using them.

Almost all of the participants had heard of AIDS. However, only 60% of the participants were able to correctly answer questions about HIV/AIDS transmission routes. There was an overall lack of understanding about the differences of HIV and AIDS among all the participants. No one knew of the asymptotic nature of HIV infection, and it was commonly believed that a healthy-looking individual could not possibly be infected with HIV/AIDS. Most participants felt that one should avoid all contact with individuals who manifested symptoms associated with AIDS. The discussion of AIDS conjured up fear and stigma for most of the study's migrants. However, only a few perceived themselves at risk of becoming HIV positive. The findings strongly suggest that participants perceived AIDS as a disease confined to a risk group (primarily sex workers), rather than to a sexual behavior. This perceived association fueled fear and discrimination towards sex workers, an already highly stigmatized group.

In understanding these beliefs, perceptions and behaviors of migrants from Burma in Thailand surrounding issues of sexuality and reproductive health, it is possible to consider what responses are most appropriate to address their concerns and limited knowledge base.

There should be a system to recognize migrant workers and their families, as was the case with displaced persons from Burma who arrived in Thailand prior to 1976. Research findings show that migrant workers usually migrate with families and relatives. Policies regarding migrant workers should acknowledge and include family members and relatives, and address their needs, especially health services such as emergency care, maternity, immunizations, registration of newborns, and disease control. This recognition of migrant workers' spouses and dependents does not necessarily require that they be permitted to work in Thailand, but rather provides opportunities for appropriate interventions that will serve not only the migrants, but Thai people as well, especially in regards to public health concerns.

Chapter 8
Summary and Considerations

The aim of this study was to document the perceptions, concerns, and realities of female migrants from Burma living in Thailand (along with others in their community) to better understand their lives and reproductive health concerns and realities. The primary goals of the study were to:

1. Identify the constraints and opportunities for improving the reproductive/sexual health of these women and preventing violence against them;
2. Recommend intervention strategies at the structural, relational, and individual levels; and
3. Identify questions and areas for further research.

The participants in this study were undocumented migrants living in Thailand who first left Burma in or after 1988. Those interviewed were of the reproductive age of 15-50 years, in order to highlight current reproductive health perspectives and concerns. Three different provinces with varied industries heavily employing migrants from Burma were purposively selected: Chiangmai Province in the north, Ranong Province in the south, and Mahachai Sub-District of Samutsakorn Province, near Bangkok.

Data collection was carried out in two phases. During Phase One, the formative phase, in-depth interviews and focus group discussions were held from late January to mid-April 1998. A total of 62 female migrants, 37 male migrants, and nine key informants were interviewed and 39 focus group discussions took place. During Phase Two, a structured survey with a much larger population sample was carried out from May to July 1998, which permitted the gathering of quantitative data that was cross-analyzed with Phase One' s qualitative data. For the survey, 827 participants were randomly and successfully recruited. In Ranong, 418

migrants (210 females/208 males) were interviewed. They were selected from fish processing communities (172 cases), sawmills (145 cases), and plantations (101 cases). In Chiangmai, 409 migrants (218 females/191 males) were chosen from construction sites (229 cases), small factories (90 cases), and service industries (90 cases).[46]

A summary of the study's findings, recommendations, and areas for further research is provided in the next section. The findings are discussed according to migrants' constraints and opportunities at individual, relational, and structural levels. Policy implications and areas for further studies were developed based on the findings, as well as from reflections and discussions at two provincial workshops and one national workshop.[47] It is anticipated that this information will provide policy makers, donors, and service providers with critical information and background for addressing migrants' reproductive health concerns and needs.

8.1 Migrants' Constraints and Opportunities

The study found a wide range of constraints and opportunities for intervention in addressing the sexual and reproductive health of Burmese migrants. These constraints and opportunities are often inseparable and, therefore, are summarized together below.

8.1.1 Individual

Before leaving Burma, almost all the migrants had anticipated the hardships they would likely encounter in Thailand. Most of them owned land and were employed prior to leaving Burma. However, harsh economic conditions and threats to their survival and security, including political violence, were the predominant reasons given for migrating to Thailand and for staying on, even though the migrants noted that life in Thailand was not economically profitable (This will be discussed further in section 8.1.3).

The majority of the study's migrants were illiterate or had received less than four years of formal education. The educational attainment was significantly higher among men than women and also significantly higher among Ranong participants than those in Chiangmai. In Chiangmai, where migrants were predominantly of Shan ethnicity, 38% of the women and 12% of the men reported never having received a formal education, as compared to 5% of the women and 2% of the men in Ranong who participated in this study.

Migration from Burma to Thailand often entailed the use of agents, brokers, or individuals who were familiar with routes of travel, border check points, and/or employment networks. Most migrants admitted that they entered Thailand illegally without proper

46 Due to arrests of undocumented migrants in the Mahachai area, the survey could not be carried out at this site for security reasons.

47 The purpose of all three workshops was not only to evaluate the research process, but also to disseminate preliminary research findings and engage in dialogue with local community members. The two provincial workshops were held in Chaingmai and Ranong on July 21 and 23, 1998, respectively, and the national workshop was held on July 26, 1998, in Bangkok.

documents to live and work in Thailand. Consequently, they reported living in fear of extortion, arrest, and deportation. Many migrants encountered abuses and exploitation enroute to and while residing in Thailand, but claimed that these were more tolerable than their lives in Burma.

Most of the migrants resided in only one province and did not migrate elsewhere in Thailand. However, those in Chiangmai relocated frequently within the province compared to their counterparts in Ranong. This was primarily because the Chiangmai participants largely worked and resided at construction sites and would move to different project worksites as needed. All of the participants reported rarely leaving their place of residence and/or work because of fear of arrest, with women perceived as being at greater risk. Within these realities, men reported going outside of their place of residence and/or work more often than women.

Although the migrants lived in a variety of different accommodations, they were all typically over-crowded and of sub-standard quality. Most migrants cooked and slept in the same small room. Sanitation was a chronic problem in all areas, which lacked garbage and sewage disposal, clean drinking water, washing and bathing facilities, and sufficient numbers of toilets. Migrants consistently complained about the lack of clean water and sanitary conditions in which they were forced to live. They also frequently complained about their inability to access clean and safe water. As a result, over half (52%) of all participants reported having had diarrhea and one-third of them had experienced skin diseases.

Serious health problems among migrants emerged from this study (see Chapter 3), corraborating that of previous studies, including malaria, maternal mortality, injuries, infant mortality, diarrhea, skin rashes, and depression. Deaths from malaria, childbirth, and workplace injuries were not uncommon. Infant morbidity was also frequently a significant cause of death, although in most instances the illness attributed to the death was unknown. The incidence of death from malaria was highest among the various health problems and appeared to result from a lack of understanding of the signs and dangers of the illness and the need for proper treatment, as well as an inability to access available services.

Regarding complications during and after childbirth, nearly 90% of the respondents regarded such problems as serious, with one-third noting it as an extremely serious problem. Among Ranong participants, the majority of births, both in Burma and Thailand, were delivered at home.

Injuries encountered at the workplace were frequently reported. Forty percent of all respondents had endured injuries while working in Thailand, with some serious and fatal injuries reported by family members and co-workers.

Participants at all three research sites reported little or no knowledge or access to contraceptives while in Burma, but increased use in Thailand. Hormonal contraceptives, taken either as pills or injectibles, were the most commonly reported forms of birth control used in both Chiangmai and Ranong, with a wide range of other methods reported to a lesser extent. The vast majority of respondents had heard of condoms (91%), but only 13% had ever used them. Not surprisingly, men were more experienced with condom use than women. Although many of the respondents knew that condoms protected against diseases, such as AIDS, most expressed a lack of interest in using them.

Among married couples currently living with their spouse, 62% of them did not want additional children, but more than half of them (54%) were not using any birth control. Among migrants who reported themselves or their wives as ever having an unwanted pregnancy, 17% of them attempted abortions. Of those, only 45% were successful. Women migrants at all three research sites reported serious side effects from abortions. The reasons for seeking abortions were typically one of the following: not yet married, too many children, or not in a secure situation to raise children.

Participants throughout the study were unable to correctly identify or describe types or symptoms of reproductive tract infections. In addition, there were few words in their vocabulary that could define or even distinguish the different types of infections. On the contrary, almost all participants had heard of AIDS (98%). However, they could respond correctly to only 60% of the questions about HIV/AIDS transmission routes. There was an overall lack of understanding about the differences between HIV and AIDS, and no respondent was able to explain the asymptomatic nature of being HIV positive.

The main factors determing migrants' health-care decisions were their illegal status, lack of financial savings, and inability to communicate in the Thai language. The majority of migrants first sought to address their health care needs by purchasing drugs or seeking traditional care givers or health methods. Public services were identified as available for emergency cases or for childbirth.

8.1.2 Relational

Nearly three-fourths (72%) of all migrants had ever been married and approximately the same percentage (78%) currently lived with their spouse. The majority of married couples had wed before the age of 20. They had an average of 2.09 children, compared with the overall fertility rate of 3.5 in Burma (Human Development Report, 1998). Once in Thailand the majority of the study's participants did not return to Burma and had not maintained contact with their family back home.

Marital status and gender were major factors in determining the type of work available to migrants, the salary they received, the terms of employment, and the working conditions. Women consistently received less pay than men, even in similar occupations. In addition, if a couple worked in the same place, employers were more likely to register only the male migrant for an official work permit. Because of certain restrictions, family members of migrants have not been allowed to register for permits, adding to the vulnerability of women and children. Single girls and women were reported as most vulnerable. Once in Thailand, a significant number of migrant girls and women reported marrying for protection. Both women and men reported violence in their community and within the home, with women again being most at risk. Such violence included incidents of robbery, rape, and murder.

The majority of migrants from Burma reported residing in their own communities and not mixing with Thai nationals. Most migrants reported unable to use the Thai language to communicate their basic needs (this was reported even among Shan migrants whose language is most similar to Thai). This greatly limited the integration of migrants into Thai society, as did their tenuous or illegal status.

Regarding sexuality, the majority of participants reported extremely different sexual norms for males and females, with strong values of virginity associated with girls and women. Loss of virginity for females not yet married often resulted in serious consequences. Boys and men were seen as having a greater sexual drive and being more sexually active prior to marriage. Commercial sex patronage by males was described as a common social event. Social norms supported single men visiting sex workers, but it was seen as less tolerable for married men.

Changes in sexual norms were reported due to different lifestyles, exposure to urban life, and migration out of tight social networks back in Burma, particularly among females. Many migrants, especially young people, found themselves in communities where the social norms and controls from their homelife did not exist and were considered not applicable. In general, participants reported a lack of knowledge and access to information regarding sexuality and reproductive health. Sexual and reproductive health issues were rarely discussed by migrants, particularly among females. The extent of information and discussion on sexual and reproductive health topics varied according to gender and the level of formal education obtained.

Participants at all three research sites reported limited or no access to and use of contraceptives in Burma. The majority of those interviewed reported using contraceptives that they had purchased from mobile markets, small kiosks, or over the counter drug stores. Only one third of the participants reported receiving their contraceptives from a medical clinic or hospital. All participants reported lacking and wanting information on specific types of contraceptive methods and side-effects, particularly oral contraceptives and injectibles.

Among migrants who had reported attempting to abort a pregnancy, only 18% of abortions were performed by health personnel. The majority of women in Ranong self-induced or sought a friend to help. This was significantly different from the majority of women migrants in Chiangmai who reported seeking abortions through a traditional birth attendant. Women at all three sites reported serious side effects and health risks from abortions.

The findings strongly suggest that participants perceived AIDS as a disease confined to a risk group, primarily sex workers, rather than a sexual behavior. This perceived association fueled fear and discrimination towards sex workers, an already highly stigmatized group. Condoms were associated with sex workers and understood as important in this context to prevent HIV/AIDS. Condoms generally represented mistrust and promiscuity, while not using a condom symbolized trust and loyalty to one's partner. Many women reacted negatively to condoms while men did also, but to a lesser extent.

Overall, the common belief among the participants was to avoid contact with individuals who manifested symptoms associated with AIDS, and that a healthy looking individual could not possibly be infected with HIV. The discussion of AIDS conjured up fear and stigma for most migrants in the study and only a few perceived themselves at risk of being HIV positive.

8.1.3 Structural

Migrants consistently noted the interconnectedness of political and economic conditions when discussing their reasons for migrating to Thailand and consequently did not distinguish

between such labels as 'refugee,' 'displaced person,' or 'economic migrant.' Accounts of war and political repression, forced relocations, conscription of laborers and porters, rape, taxation, and/or harassment in Burma were often reported.

Chiangmai respondents, who were predominantly from the Shan State, reported more frequent incidences of such abuse. Migrants in Mahachai and Ranong reported indirect violence, such as heavy fines and taxes, coercion, and economic policies that undermined their survival, though some also reported accounts of political repression that resulted in psychological and physical violence. However, these incidents of political repression were not as severe as those reported by the Chiangmai participants.

Once in Thailand, undocumented migrants were allowed temporary work permits if they worked in certain sectors and provinces, and if their employers were willing to apply on their behalf as a guarantor. The Thai government's efforts to register migrant workers has depended entirely on the cooperation of employers and their willingness to uphold the rights provisioned for migrant employees. Employers are required to accompany the employees through the entire registration process and migrants are not allowed to register on their own behalf.

Expenses for registering each migrant included, a 1,000 baht fee for 'bail', a 1,000 baht fee for a one-year work permit, a 500 baht fee for a medical check-up (which was increased to 700 baht in 1999), and a 1,000 baht for a one-year health care card. In practice, the employers paid the fees and then deducted these expenses from migrants' wages. Though official policies have been revised on several occasions, they follow the same premise and process.

Most migrants from Burma have not registered and the majority of women and children are excluded from the registration process. Since no translation of the registration procedures and rights are provided to the migrants, the process has not been clearly understood, thereby forcing migrants to rely even more heavily on their employer for explanation and compliance with official policies. In addition, participants frequently reported that their employers kept their work permits, further limiting the migrant's legal rights and access to protection. Finally, there has been no effort by the Thai government to deal with the corruption and extortion that has unfolded around the registration process.

The migrants in this study consistently reported abuses encountered in Thailand, primarily as a result of their illegal status. They reported being cheated and harassed, as well as arrested and deported, regardless of whether they possessed a work permit. Over one-third of the participants had been arrested at least once by Thai police or soldiers, who either extorted money from them for their release or detained and deported them to the border. The arrests escalated during the period of this study, with massive crackdowns ordered in response to the economic downturn that resulted from the Asian financial crisis. Another one-third (38%) of the migrants reported being cheated or abused by their employers or at their workplace.

It is apparent that undocumented migrants consistently live under fear and frustration from a wide range of abuses that may occur at any time, anywhere. There exists very limited resources, forms of legal protection, or social support for migrants to turn to when they encounter such violence. The only recourse for this abuse, according to the participants, is to quit and seek a new job. However, as the economic crisis resulted in reduced job opportunities, migrants found even this option less viable.

Migrants saw assistance from their employers (providing the necessary negotiation and/or financial support) as the only means of accessing health providers, either public or private. Public health services were identified as available for emergencies or childbirth. Private health services were reportedly preferred because of their proximity and anonymous nature, although more expensive. Migrant workers in Ranong had the additional option of returning across the border to access health services in Burma.

Given the tenuous relationship of many migrants with their employers, Thai officials, and Thai society, many migrants explained the general trend in their community was to avoid seeking health services until one's health deteriorated and faced a life-threatening situation. Many migrants noted the need for an amnesty from arrest when seeking health services, as well as translation and referral mechanisms with traditional or community-based health care providers. A few non-governmental organizations (NGOs) have attempted to provide some of these services, but have had varying degrees of success.

8.2 Policy Implications

Undocumented migration has the potential to cause serious security problems both within each country and between countries. The later is often vulnerable to the potential for misunderstandings between sending and receiving countries. The first part of this section therefore recommends the Thai government to modify its policy in relation to the government of Burma. Findings in this study suggest that changes in approaches of domestic policy regarding migrant workers and social status of migrants are required to formulate more humane and effective management of undocumented migrant workers. Health care policy regarding migrant population is another important consideration necessary to improve the quality and well-being of migrants as well as the larger community.

8.2.1 Foreign Policy

Migration from Burma is rooted in the country's political and economic problems. Human rights violations and anti-democratic movements effected by the government have not abated. Authorities continue to carry out policies of forced labor and the relocation of minorities, which in turn perpetuates internal struggles and armed conflict. Without addressing these realities directly with government officials, mass migration of Burmese into Thailand will continue. Efforts by Thailand alone, such as repatriation, will not solve this problem. Furthermore, since many of those leaving Burma do so for economic reasons, the trafficking of illegal labor into Thailand is likely to increase. The Thai government must work with the international community, as well as directly with the Burmese government to address migration flows from Burma.

(1) At the multilateral level. It is necessary for Thailand and the global community to take active steps in encouraging the Burmese government to develop and improve their democratic and human rights perspectives. The ASEAN countries should work with East Asian countries, such as China and Japan in an attempt to bring about changes in the current deadlock and insist that the Burmese government acknowledge the democratic elections and basic rights of its citizens.

A democratic process must accompany economic development. The role of ASEAN countries should be to ensure that investment in Burma be tied to democracy and upholding the human rights of the people of Burma. Furthermore, business investment and democratic development must result in the benefit of the people and should not destroy Burma's natural resources and environment.

In April 1999, representatives of East Asian and South Asian countries began this process at a conference entitled: Towards Regional Cooperation on Irregular/Undocumented Migration. This meeting was a progressive step forward in addressing key issues on a multi-lateral level with the government of Burma. As a result, the government of Burma acknowledged the issues discussed at the meeting, particularly regarding the number of migrants from Burma residing in Thailand and eventually Burma agreed with the Bangkok Declaration on Irregular Migration.

(2) At the bilateral level. For the past three years, the Thai government has attempted to bring irregular and undocumented migration issues into discussions at ASEAN meetings. The recently signed Bangkok Declaration on Irregular Migration has provided the governments of Thailand and Burma with a means for initiating further action, particularly on articles 10 and 12 below.

> *Article 10. The countries of origin, transit, and destination are encouraged to strengthen their channels of dialogue at appropriate levels, with a view to exchanging information and promoting cooperation for resolving the problem of illegal migration and trafficking in human beings.*

> *Article 12. Concerned countries, in accordance with their national laws and procedures, should enhance cooperation in ascertaining the identity of undocumented/illegal migrants who seemingly are their citizens, with a view to accelerating their readmission.*

The next step for Thai-Burmese bilateral cooperation is to establish a joint committee to strategically plan to uphold the rights of undocumented migrants and provide a means by which they can return home safely, without repercussions and a guarantee of basic rights ensured to all citizens.

8.2.2 Policy Regarding Illegal Migrant Workers from Burma

Policies on migrant workers in Thailand must be developed on both the national and provincial levels, with a framework for implementation that includes input and responsibilities from officials at both levels. First, the Thai government must decide which provinces can legally accept migrant workers. Second, these designated provinces should provide work permits for migrant workers, based on the province's need for labor and be responsible for the design and implementation of appropriate public health and disease control policies. Provincial committees should determine and manage the sectors of work and permit procedures based on the conditions of their respective provinces.

Provincial committees should be organized along the lines of civil organizations, where members' backgrounds and disciplines are diverse. For example, provincial committee members should include staff members from the provincial employment office, the office of immigration, the local police department, the provincial health center, and representatives from local organizations, such as provincial administration, business owners, local NGOs, and academics.

There should be a system to recognize migrant workers AND their families, as was the case with displaced persons from Burma who arrived in Thailand prior to 1976. Research findings show that migrant workers usually migrate with families and relatives. Policies regarding migrant workers should acknowledge and include family members and relatives, and address their needs, especially health services such as emergency care, maternity, immunizations, registration of newborns, and disease control. This recognition of migrant workers' spouses and dependents does not necessarily require that they be permitted to work in Thailand, but rather provides opportunities for appropriate interventions that will serve not only the migrants, but Thai people as well, especially in regards to public health concerns.[48]

Since registration of migrant workers needs the cooperation of many parties, it is critical that all the parties realize the importance of the registration process. Information and directives should be clear on all levels, from those of national authorities to the provinces to the migrants themselves. This requires open communication and on-going evaluation of policies and procedures in order to understand what is working and what is not for each of the parties concerned.

Translation of policies and procedures related to migrants should be made available in their language and actively distributed. NGOs assisting migrant workers could provide technical support in the translation and dissemination of information. A clear understanding will broaden migrant workers' ability to protect themselves from labor trafficking and from those employers and authorities who do not uphold the established policies and processes.

Police and immigration officers consistently refer to migrants from Burma as illegal and not deserving of any kind of assistance. It must be acknowledged that all people have basic rights regardless of their documentation or lack of and should not be assumed criminal or 'illegal' simply because they are not registered as Thai citizens.

The Thai government should develop some kind of mechanism to protect migrant workers' rights. Research findings suggest that when migrant workers are cheated or abused they seek to escape their situation, while the violators, be they state authorities, employers, or others, are not held accountable for their acts. An Office of Migrant Workers should be established to at least provide protection and redress to those migrant workers and their families who are registered. Collaboration with NGOs in offering assistance to undocumented migrants could provide a means for support to such an office in implementing their work. The

48 At the workshops in Chiangmai and Ranong, ptovincial health officers and business owners emphasized that the policies on migrant workers should include workers' dependents, although this does not necessarily mean permitting their dependents to work in Thailand.

Human Rights Protection Committee, to be established by the Thai Parliament by the end of the year 2000, could be another body to assist in protecting the rights of migrants.

8.2.3 Policies Related to the Social Status of Migrant Workers

This study found that migrants in Chiangmai are mostly those fleeing Shan State as a result of grave human rights violations, largely imposed by the government of Burma. These individuals are clearly seeking political refuge in Thailand, not simply economic opportunities. However, once in Thailand, many seek to work in order to survive. The Thai government must recognize and be sensitive to the reasons for migration and provide shelter to this population, as they do for other refugees from Burma. By doing so the Thai government will be better able to document and manage the increasing number of undocumented Shan in the country. Support for Shan refugees could be negotiated with international and non-governmental organizations. An official acknowledgement of the need for asylum among the Shan population in Thailand would provide a practical means of assessing the situation and an appropriate repatriation policy when possible.

The Thai government should also develop a clear policy regarding children born to migrants in Thailand, as well as migrant children traveling with their parents, and children who migrate on their own or are trafficked into Thailand by labor smuggling groups. The following two responses should be considered:

- **Registration of newborns.** Article 523 of the 1992 Registration Administration Bureau states that the registrar must register newborns regardless of their parents' legal status (Registration of newborns does not include the granting of Thai citizenship). In practice, hospital personnel and local registrars do not understand the procedure and, therefore, often do not certify or register the birth. The Thai government in turn fails to maintain a database of migrants' newborns. Existing data is scattered among various government units. The Ministry of Interior, should be the authority to give the directive informing involved organizations, employers, and migrants of the regulation and to begin to address the problems faced by migrant children.

- **Documentation of Children under 15 years of age.** Since Thailand does not have a policy to enumerate or register migrants in anyway other than to register them for work purposes, people under the age of 15 who are not eligible to work are not registered or even identified. When children under 15 years old do work (whether they migrate with or without their parents), they are not acknowledged because their employment is considered illegal. The Thai government lacks information on these young people. The only information available is from NGOs working with migrant children or conducting research on issues that relate to them.

In addition, more conditions should be set forth for businesses employing migrant workers. There is a critical need to address the sanitation conditions surrounding migrant workers' residences and workplaces. Employers and government departments must work together to

ensure adequate sanitation and facilities for migrant workers. Healthy communities and work environments for migrants protect not only the migrants, but also all those living and working in the surrounding communities. There must be a means for holding employers responsible for these conditions and consequences for those who do not comply.

As discussed earlier, providing information and opportunities for communication with migrants regarding their situation and the problems they encounter is critical. Provision of interpreters and materials should be available in the migrants' languages and distributed to migrant communities in collaboration with NGOs. Migrants and employers should also be informed of the issues raised and strategies for improving the registration and rights of migrants' working in Thailand.

8.2.4 Policies Regarding Health Care Services

Creative approaches to health care services have been conducted in Ranong, Mae Sot, and other districts in Chiangmai and Mahachai where local organizations have coordinated and supported referral systems between migrant communities and Thai hospitals. This requires strengthening the local infrastructure of service providers, advocates, and community-based organizations (CBOs), as well as increased collaboration between Thai authorities at the provincial level and local NGOs, CBOs, hospitals and clinics. One option would be to recruit migrants as health volunteers and provide training to them to care for people in their own communities.

Reproductive health education should take into consideration the migrant's languages, literacy levels, and cultural differences. Some specific areas of reproductive health to be addressed are pregnancy, delivery and post-natal care, contraception, abortion, reproductive tract infections, and HIV transmission.

Given the high incidences of malaria and other serious health problems, health education should be provided to migrant communities. The education should range from preventive education to information on access to malaria testing and health services. Again with attention to their languages and their limited literacy skills.

Efforts to promote HIV prevention should disassociate HIV infection from at-risk groups, such as sex workers and fishermen and focus instead on risk behavior. This recommendation does NOT suggest that programs should not allocate resources to groups engaged in high-risk behaviors, but emphasize the behavior not particular individuals or occupations. It is critical to continue to focus on behavior and ensure that certain groups are not further stigmatized by targeted strategies.

In terms of migrants' health care expenses, stakeholders involved in migration issues should take part in bearing some of these costs. Providing basic health insurance is one way to help decrease the problems. Recently, the Thai government announced a policy for all migrants to purchase health insurance at a 1,000 baht for the employed migrant, and 200 or 300 baht for each additional family member. This policy should be continued and expanded.

Support for the development of educational materials, production of the materials in the migrants' languages, and the distribution of the materials to reach as many migrants as possible should be developed. The educational materials should include information on

general health protection, reproductive health issues and communicable diseases, such as malaria, TB, and HIV/AIDS.

8.3 Recommendations for Future Research

Various groups of migrants, such as children, sex workers, and displaced persons facing human rights violations should be protected. Developing practices to protect migrants from these violations and seek redress are desperately needed. Active negotiation to develop and implement a repatriation policy to combat the high number of migrants in Thailand could reduce the number of migrants, but indirectly increase their vulnerabilities to abuse. Therefore, until systems for protection and redress are in place repatriation schemes will not be a viable option.

Future research should focus on how best to establish an effective health care system that includes disease control strategies for migrants. Such a system should consider developing a "migrants health database" that could be used by the Health Ministry and others to develop appropriate health policies. The database could also support the development of necessary and adequate social and health services, such as education and immunization for children.

In addition, further in-depth studies of migrants' health beliefs and practices should be considered. These studies could help to establish health care services thar respond to the needs of migrants and more specifically to their realities. In-depth studies are needed, especially in the areas of women's reproductive tract infections and beliefs and reactions among migrants towards HIV infected people and AIDS patients. Operational research may be necessary to look at antenatal care and postpartum care for migrants.

Finally, future studies should focus on factors affecting migrants' access to health care services, quality of care provided to migrants, as well as the attitude of Thai health care providers toward migrants.

References

References

In Thai

Archavanitkul, K. (ed.). (1998b). *Undocumented Migration from Myanmar to Thailand and Its Impact on Thai Society.* Paper presented at the Seminar on 'Migrant Workers from Myanmar: Impact on Thai Society and International Relations'. Organized by the Institute for Population and Social Research, SD Avenue Hotel, Bangkok, March 12.

Archavanitkul, K., Jarusomboon, W., & Warangrat, U. (1997a). *Complexities and Confusion on Transnational People in Thailand.* Nakhonpathom: Institute for Population and Social Research, Mahidol University.

Archavanitkul, K., Pinprateep, W., Khajontham, P., & Prietipinyo, C. (1997b). *Fertility, Morbidity and Mortality of Undocumented Migrants with Reference to Public Health Policy in Thailand.* Nakhonpathom: Institute for Population and Social Research, Mahidol University.

Archavanitkul, K. & Koetsawang, P. (1997). *A Passage of Women from Neighboring Countries to Sex Trade in Thailand.* Nakhonpathom: Institute for Population and Social Research, Mahidol University.

Koetsawang, P. & Archavanitkul, K. (1997). *Human Rights Violations in Burma: From Refugees to Migrant Workers in Thailand.* Nakhonpathom: Institute for Population for Social Research, Mahidol University.

Pattarakulwanich, Somsak, Somsong Rugpao, Ladda Likityingwara, and Ongrat Chareonsuk. (1999). Public Health burden at the borders during 1997-1998. *Journal of Health Science. Vol.8. No.2. pp. 156-163.*

Sawadirak, Somchoke. (1997). *Thai-Burma-Karen Relationships.* Bangkok: Foundation for Text in Social Sciences and Thailand Research Fund.

Sawaddiwudhipong, Witaya, Chaveewan Chaovakiratipong, Patchree Nguntra, Pranee Mahasakpan, Woralux Jaisaad, and Somyot Leetrakul. (1999). Expanded program on immunization in Myanmar migrant children in Mae Sot, Tak Province, 1998-1999. *Journal of*

Communicable Diseases. (forthcoming).

Thammapalo, Suwich. (1996). *Elephantiasis in Burma.* An unpublished Thai manuscript translated from unpublished document of Ministry of Public Health of Burma, pp. 77-91.

The Registration Administration Bureau. (1999). *Acts and Regulations related to Management of Minority Population in Thailand.* Bangkok: Ministry of Interior.

Wattanasri, Naiyana, Somsak Wattanasri, Pakana Tantivaranont, Achariya Makthiengtrong, and Napa Pathomyothin. (1998). Viral Hepatitis Infection among Myanmar workers, Ranong Provijnce, 1997-1998. *Journal of Health Science.* Vol.7.No.4. pp. 440-446.

In English

Adams, A. & Castle, S. (1994). Gender Relations and Household Dynamics. In Sen, G., Germain, A. & Chen, L.(eds.), *Population Policies Reconsidered: Health, Empowerment, and Rights.* Boston: Harvard School of Public Health.

Archavanitkul, K. (1998a). *Combating the Trafficking in Children and their Exploitation in Prostitution and Other Intolerable Forms of Child Labor in Mekong Basin Countries.* A research report submitted to the International Labor Organization [ILO/IPEC - International Program of the Elimination of Child Labour], Bangkok.

Archavanitkul, K. (1998c). *Policy Options for Importation of Foreign Labor into Thailand: A Synthesis Report.* Paper presented at the Regional Workshop on 'Transnational Migration and Development in ASEAN Countries.' Organized by the Institute for Population and Social Research and International Organization for Migration, Bangkok and Hua Hin, Thailand. May 25-27.

ALTSEAN. (1997). *Burma and the Role of Women.* Bangkok: Author.

Amnesty International. (1998). *Myanmar: Atrocities in the Shan State.* London: Author.

Asia Watch. (1992). *Burma: Rape, Forced Labor and Religious Persecution in Northern Arakan.* New York: Human Rights Watch.

Asia Watch. (1993). *A Modern Form of Slavery: Trafficking of Burmese Girls and Women into Brothels in Thailand.* New York: Human Rights Watch.

Asian Research Center for Migration. (1995). *Report of the Technical Consultation on Information Regarding Population Movements and HIV AIDS.* Bangkok: Chulalongkorn University.

Asian Research Center for Migration. (1997). *Report of Second Technical Consultation on Transnational Population Movements and HIV AIDS in Southeast Asian Countries.* Bangkok: Chulalongkorn University.

Aye Aye Thein, Ba Thike, K. & Myint Maung Maung. (1995). *A Study on Teenage Pregnancy in North Okkalapa.* Yangon: Myanmar Research Congress.

Ba Thike, K. (1997). Abortion: A Public Health Problem in Myanmar. *Reproductive Health Matters,* 9, 94-100.

Ba Thike,K., Khin Thet Wai, Nan Oo, & Khin Htar Yi. (1993). Contraceptive Practice Before Female Sterilization. *Asia-Ocenia J. Obstet. Gynaecol, 19,* 241-248.

Ba Thike, K., Khin Thet Wai, Le Le Win, Saw Kler Khu, Myint Maung Maung, & Thein Hlaing.

(1992). Socioeconomic Differentials of Women with Severe Septic Abortions. *Myanmar Medical Journal*, 37, 1-4.

Battistella, G. (1995). Migration and Trafficking: The Perverse Link. *Asian Migrant*, 8, 3-7.

Bennett, Tony. (1997). Border crossing and HIV: AIDSCAP identifies environment risks. *AIDSCAPTION*. Vol.IV. No.1:pp.31.

Bernard, R.H. (1995). *Research Methods in Anthropology: Qualitative and Quantitative Approaches.* London: Sage Publications.

Beyrer, C. (1998). *War in the Blood: Sex, Politics, and AIDS in Southeast Asia.* Bangkok: White Lotus.

Bo Kywe & Maung Maung Lin. (1993). *Birth Spacing Practices in Twenty Townships in Six Divisions* (unpublished). Yangon: Community Health Care Project, Department of Health.

Burma Project. (1998). *Burma: Country in Crisis.* New York: The Open Society Institute.

Center for the Study of Human Rights. (1994). *Twenty-five Human Rights Documents.* New York: Columbia University.

Central Statistical Organization. (1995). Yangon: Author.

Chelala, C. (1998). What's Ailing Burma?: The State of Women and Children's Health. *Burma Debate, 5,* 28-37.

Chintayananda, S., Risser, G. & Chantavanich, S. (1997). *The Monitoring of the Registration of Immigrant Workers from Myanmar, Cambodia and Laos in Thailand.* Bangkok: Asian Research Center for Migration, Chulalongkorn University.

Department of Health. (1995). *National AIDS Control Programme in Manipur.* Manipur: Government of India.

Department of Health. (1996). *HIV/AIDS In Myanmar (Burma): An Epidemiological Perspective,* Yangon: Author.

Earthrights International. (1998). *School for Rape: Burmese Military and Sexual Violence.* Bangkok: Author.

Economic Intelligence Unit. (1998). *Country Profile: Myanmar (Burma) 1997-1998.* London: Author.

Figa-Talamanca, I. (1986). *Illegal Abortion: An Attempt to Assess its Cost to Health Services and its Incidence in the Community.* Manuscript submitted for publication.

Freedman, L.P. (1994). *Law and Reproductive Health.* Washington D.C.: Island Press.

Freedman, L.P. (1995). Censorship and Manipulation of Reproductive Health Information. In Article 19 (eds.), *The Right to Know: Human Rights and Access to Reproductive Health Information.* London, Author.

Gittelsohn, J., P.J. Pelto, P.J., Bentley, M.E., Bhattacharyya, K. & Russ, J. (1995). *Women's Health Network Protocol: For Using Ethnographic Methods to Investigate Women's Health. Baltimore:* John Hopkins University.

Gostin, G. & Mann, J. (1994). Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies. *Health and Human Rights,* 1 (1), 59-80.

Government of Myanmar [GOM] & United Nations Population Fund [UNFPA]. (1994). *Project Agreement: Strengthening of Birth Spacing Programs.* Yangon: Authors.

Government of Myanmar. (1997). *Trafficking in Women: A Myanmar Perspective.* Paper presented at the meeting of the Mekong Regional Law Center on Trafficking. Bangkok, Thailand, November.

Hla Pe, Khin Khin Aye, Malar Myint, May Thet Khine, Thein Thein Htay, Than Than Yin, Lwai Mu Mi Thar, Than Myint Soe, Kyawt Khin, Nyo Le Fyi, Kyaing Kyaing Sein, Khin Tint, Kareng Lu, Aye Kyi Sein, Khin New Yi, Kyin San Win, Khin Mar Ol, Khin Aye, Lay Yu, Soe thein, Kyaw Shein, Tin Win, Mg Mg Than, Sein Win, Myunt Aung, Hla Win, Yee Yee, Joseph, Thein Swe, Mg Mg Lin, Le Le Yi, Than Myint, & Myo Thet Htoon. (1992). Birth Spacing Practices Among the Rural Populations of Kyo-Kone and Sarbu-Daung Rural Health Centers in Hlegu Township. *Myanmar Medical Journal, 37,* 1-11.

Human Rights Watch. (1997a). *Rohingya Refugees in Bangladesh.* New York: Author.

Human Rights Watch. (1997b). *Burma/Thailand: No Safety in Burma, No Sanctuary in Thailand.* New York: Author.

Images Asia. (1998). *All Quiet on the Western Front: The Situation in Chin State and Sagaing Division, Burma.* Chiangmai: Author.

Kaewsonthi, S. and Harding, A.G. (1992). *Starting, Managing and Reporting Research.* Bangkok: Chulalongkorn University Ptess.

Khin Than Tin & Khin Saw Hla. (1990). *Causes of Maternal Deaths in Affiliated Teaching Hospitals.* Yangon: Myanmar Medical Association.

Krasu, M. (1992). An Overview of Maternal Morbidity in Myanmar. *Proceedings of a Seminar on Maternal Morbidity Obstetric and Gynecological Section.* Yangon: Myanmar Medica Association.

Krueger, R. (1994). *Focus Group: A Practical Guide for Applied Research.* Thousand Oaks, CA: Sage Publications.

Kyaw Tint. (1983). *A Knowledge Attitude and Perception Study on Child Spacing Behavior in Peri-urban Areas.* Paper presented at the Burmese Medical Association, Second Medical Specialties Conference, Yangon, Myanmar.

Lintner, B. (1994). *Burma in Revolt.* Bangkok: White Lotus.

Mann, J., and Gruskin, S. (1995). Women's Health and Human Rights: Genesis of the Health and Human Rights Movement. *Health and Human Rights,* 1, 309-314.

McConville, F. (1995). *A Rapid Participatory Assessment of the Health Needs of Women and Their Children in an Urban Poor Area of Myanmar.* Yangon: World Vision.

Min Thwe, Bo Kywe & Goodwin, D.J. (1995). *HIV Surveillance in Myanmar, 1985-1995.* Paper presented at the Third International Conference on AIDS in Asia and the Pacific. Chiangmai, Thailand.

Ministry of Health. (1992). *Report of the Seminar on National Population Policy.* Yangon: Department of Planning and Statistics.

Ministry of Health & United Nations Population Fund [UNFPA]. (1999). *A Reproductive Health Needs Assessment in Myanmar.* Yangon: Authors.

Ministry of Home Affairs National Population Committee. (1994). *Myanmar National Report on Population.* Yangon: Author.

Ministry of Home Affairs. (1992). Myanmar Population Changes and Fertility Survey, *A Preliminary Report* (unpublished). Yangon: Immigration and Manpower Department.

Myint Myint Soe, San Shwe, Than Than Tin, Le Le Win, Mya Thida, & Khine Sanda. (1995). Prescribing Practices on Contraception Among General Practitioners and Basic Health Services Staff in Taikkyi Township. *The Myanmar Health Sciences Research Journal,* Vol. 7, No. 3.

National Research Council. (1997). *Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions.* Washington DC: National Academy Press.

Openheimer, E., Bunnag, M. & Stern, A. (1998). *HIV/AIDS and Cross-Border Migration: A Rapid Assessment of Migrant Populations along the Thai-Burma (Myanmar) Border Regions.* Bangkok: Asian Research Center for Migration, Chulalongkorn University.

PATH (Program for Appropriate Technology for Health). (1992). *Border Area Drug Abuse and AIDS Project Assessment: Myanmar/Thai Border.* Bangkok: Author.

Pollock, J. (1996). Women, Discrimination and HIV. *Asian Migrant,* 9, 4.

Population Reports. (1996). *People on the Move: New reproductive health focus.* Baltimore: John Hopkins School of Hygiene and Public Health.

Porter, D. (1995). *Wheeling and Dealing: HIV and Development on the Shan State Borders of Myanmar.* New York: United Nations Development Programme (UNDP).

Pyne, H. H. (1992). AIDS and Gender Violence: Enslavement of Burmese women in the Thai Sex Industry. In Peters, J. and Wolper, A. (eds.), *Women's Rights, Human Rights.* New York: Routledge.

Rainforest Action Network. (1993). *Southeast Asia Rainforests: A Resource Guide and Directory.* San Francisco: Author.

Sen, G., Germain, A., & Chen, L. (eds.). (1994). *Population Policies Reconsidered: Health, Empowerment, and Rights.* Boston: Harvard School of Public Health.

Shan Human Right Foundation. (1998). *Dispossessed: Forced Relocations and Extrajudicial Killings in Shan State.* Chiangmai: Author.

Smith, M. (1991a). *Burma: Insurgency and the Politics of Ethnicity.* London: Zed Books.

Smith, M. (1991b). *State of Fear: Censorship in Burma.* London: Article 19.

Smith, M. (1994). *Paradise Lost: The Suppression of Environmental Rights and Freedom of Expression in Burma.* London: Article 19.

Smith, M. (1996). *Fatal Silence: Freedom of Expression and the Right to Health in Burma.* London: Article 19.

Southeast Asia Information Network. (1995). *Out of Control: The HIV/AIDS Epidemic in Burma.* Bangkok: Author.

Than Than Tin, San Shwe & Thein Thein Htay. (1994). *Acceptability of Condoms Among Family Planning Clinic Attenders in Wai Baigu.* Unpublished.

Thein Thein Htay, K. Ba Thike, Khin Tet Wai, Khin Omar Sann, Nilar Tin, Khin Myin Wai, & Nu Aye Khin. (1996). *Knowledge and Practice of Service Providers in Relation to Birth Spacing.* Yangon: Department of Health, Department of Manpower, and Department of Medical Research.

Thein Thein Htay. (1996). One of the Promising Efforts. *International Review of Population and*

Reproductive Health, 48.

United Nations Development Programme [UNDP]. (1998). *Human Development Report.* New York: United Nations.

UNICEF Seminar. (1991). *Magnitude and Causes of Maternal Mortality and Morbidity in Myanmar.* Yangon: Author.

UNICEF, (1993). *Project Proposal for PF-90s Funding of Prevention and Control of HIV/AIDS in Myanmar.* Yangon: Author.

UNICEF. (1992). *Possibilities for a United Nations Peace and Development Initiative in Myanmar.* Unpublished.

UNICEF. (1995). *Children and Women in Myanmar: A Situation Analysis 1995.* Yangon: Author.

United Nations Population Fund [UNFPA]. (1996). *Country Background Report for Programming Mission.* Unpublished.

United Nations Special Rapporteur. (1993). *Myanmar: No Law at All.* New York: United Nations.

United Nations. (1996). Reproductive Rights and Health Discussed. *United Nations Chronicles.* Geneva: Author.

Valente, T.W. (1996). *Network Analysis in Public Health.* Unpublished.

Venkateswaran, K.S. (1996). *Burma: Beyond the Law.* London: Article 19.

World Health Organization. (1997). *An Assessment of the Contraceptive Method Mix in Myanmar.* Geneva: Author.

Yoddumnern-Attig, B., Attig, G.A., W. Boonchalaski, W., Richter, K. & Soonthorndhada, A. (eds.). (1993). *Qualitative Methods for Population and Health Research.* Bangkok: Institute for Population and Social Research, Mahidol University.

Zeng Yi, (1995). *The Working Situation of Controlling and Preventing AIDS in China.* Beijing: China.

ပၢႆႈသိူဝ်ၺႃႈမီ

ကျားကြောက်လို့ ရှင်ကြီးကိုး
ရှင်ကြီးကျားထက်ဆိုး

หนีเสือปะจระเข้

Run away from the tiger

but meet the bear.

ISBN 974-663-656-1