

Migrants' Health and Vulnerability to HIV/AIDS in Thailand



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Introduction

Migrants' situation in Thailand is precarious. Due to their tenuous legal status and numerous barriers that limit access to health services and legal mechanisms, migrants endure poor working and living conditions without being able to receive full or proper treatment for related health conditions. With a sense of loss of control over their life, and without being able to access health information and services in their own language, migrants' vulnerability to HIV and other reproductive health conditions increases, as does their susceptibility to contagious diseases and other health problems.

To some degree, the health status of migrants in Thailand is influenced by the health conditions they face in their home country. Accompanying low GDP, the three source countries have poor health systems that provide only limited treatment and preventative health.¹ There is also a generalized AIDS epidemic in Myanmar and Cambodia, and "source communities" for migrants that come to Thailand are known to have high prevalence rates of HIV.² Migrants' health may also be compromised by exposure to contagious diseases, such as drug-resistant strains of malaria, at border areas where many surreptitiously enter Thailand. Yet, the work and living conditions they endure in Thailand have the greatest impact on migrants' health.

This report reviews the numerous factors that affect migrants' health in Thailand, exploring work and living conditions, structural barriers to health services, and issues of emotional well-being and human rights. Information is based on informal reporting from the field, which is corroborated by a literature review. The purpose of the report is to show that migrants' health in Thailand is significantly affected by various factors that are out of their control, such as unsanitary work and living conditions and the inability to access health information and services. In part, this report refutes a common belief (and misconception) held by the Thai public (which is opportunistically echoed by the media and sometimes the government) that migrants "bring diseases." This statement has led to a perception that in order to control certain diseases, migrants must be controlled, overlooking the social and structural barriers that compromise migrants' health in Thailand. Accordingly, this report lays out the argument that both registered and unregistered migrants' inability to obtain basic rights, which is granted explicitly to registered migrants but untenable due to practical barriers, is what most negatively influences their health, and results in increased vulnerability to reproductive health problems and HIV/AIDS.

¹ Myanmar had one of the lowest expenditures on health care in the world, spending only 0.17 percent of its GDP (approx. \$5 per person in 2001) (PHR, 2004); The 2003 Gross National Income per capita in USD for these countries is as follows: Cambodia - \$ 310; Lao PDR - \$320; Myanmar - \$ 220; Thailand - \$2,190. Thailand's gross domestic product accounted for 91% of the combined GDP of Thailand, Burma, Cambodia and Lao PDR in 2003. (ESCAP, 2003)

² In 2002, Cambodia had a national HIV prevalence rate of 2.6% among adults, with rates of 1.8% and 2.3% among pregnant women in two provinces known as source communities for men who migrate for work as fishermen in Thailand (UNAIDS 2003). Rates from Myanmar date back to 2000 and are generally unreliable, however, NGOs anecdotally report very high rates of people affected by and dying of AIDS in source communities for migrants, and in ethnic areas in the north, notably the Shan and Kachin States. (PHR, 2004)

Migrant Health

In 2004, under the state registry known as TohRohDor 38/1, the total number of migrants including dependents was 1,280,053. Of that number, over 817,000 took the health exam and purchased health insurance, whereas over 814,000 received work permits. (See Table 1)

Table 1 - Provinces with the Highest Numbers of Migrants Registering, Receiving Work Permits and Taking the Health Exam, 2004

Province	Total # of Migrants Entering State Registration System (includes dependents)	Total # of Migrants Taking Health Exam **	Total # of Migrants Receiving Work Permits
National Total	1,280,053	817,254	814,247
Bangkok	204,239	179,439	152,163
Tak*	124,618	52,184	50,961
Samut Sakhorn	103,440	79,202	74,225
Chiang Mai*	82,959	25,093	48,502
Ranong*	55,749	31,546	30,158
Chonburi	50,017	40,083	33,654
Samut Prakarn	51,413	31,582	27,027

Source: Office of Administration Commission on Irregular Immigrant Workers, Ministry of Labor and Social Welfare - as of Dec. 15, 2004

*Border province with Burma

** Health exam also indicates those purchasing health insurance

The Ministry of Public Health uses the results from the health exam that is required for obtaining a work permit as a way of screening migrants for certain severe diseases. The following are *representative* results from the health exam³:

Table 2 – Results of the Health Exam, 2004

Out of 9,369 migrants classified as Type 2 (probation from work until fully treated):	Out of 676 migrants classified as Type 3 (severe health conditions that disallows them to work):
<ul style="list-style-type: none"> • 5,399 had tuberculosis • 3,092 had syphilis • 375 had intestinal worms • 273 had malaria • 222 had elephantiasis (filariasis) • 8 had leprosy 	<ul style="list-style-type: none"> • 209 had contagious stage of tuberculosis • 50 had third stage syphilis • 377 showed traces of addictive drugs • 37 were alcoholic • 2 had severe elephantiasis • 1 had severe leprosy

Source: Office of Administration Commission on Irregular Immigrant Workers, Ministry of Labor and Social Welfare - as of Dec. 15, 2004

If these numbers are held as representative, out of those tested, over 80,000 migrants could possibly have tuberculosis (9.87% of those tested), and over 45,000 migrants could possibly have syphilis (5.53% of those tested). Although it is to the Thai Government's credit that there is no mandatory testing for HIV in the health exam, it could also be argued that there is too little known about HIV prevalence rates among migrants. (See section on *HIV/AIDS*)

³ Note - the information here is incomplete, as the government has only processed or released the following results out of the 144,618 migrants identified as having a disease of concern falling under type 2 & type 3.

Although the health exam provides a glimpse of the severe diseases affecting migrants, there is little in these results that give an inkling as to why migrants suffer these types of diseases, or what other conditions are affecting migrants. Oftentimes, the disproportionate rates of disease among migrants is dismissed as being directly related to their mobile nature, especially the influx of those regularly coming over the border; however, upon deeper inspection, it becomes obvious that it is the conditions found here in Thailand that actually have the greatest influence on their health overall.

Work Related Health Conditions

Generally, beyond ISO standardization, enforcement of workplace safety standards in Thailand is inconsistent and weak. Thai workers are as susceptible to poor safety standards as migrants; however, migrants are especially prominent in occupations that are dirty, difficult and dangerous, where employers show little concern for occupational safety, and rarely provide proper safety equipment. As a result, migrants regularly suffer job-related health problems ranging from bodily injuries, to health conditions arising from environmental factors associated with the work place, such as high rates of dust, poor ventilation, or exposure to chemicals, heat or sun. The most common work related health condition among migrants, though, is fatigue and related conditions.

Table 3 - Nationalities of Migrants Registered for Work Permit by Occupation, 2004

<i>Work Category</i>	<i>Myanmar</i>	<i>Cambodia</i>	<i>Lao PDR</i>	TOTAL
Agriculture	124,539	16,621	13,363	154,523
Household worker (includes domestic worker, home care, gardener...)	88,319	8,746	31,449	128,514
Construction	81,554	24,463	8,442	114,459
Seafood processing and related industries	62,923	4,666	1,013	68,602
Fishermen (Ocean)	29,787	21,905	1,960	53,652
Rice Milling, Brick Factory, Ice Factory, Goods transport (docks and warehouses), Fish raising, Mining	20,575	3,685	1,982	26,242
Animal husbandry	19,254	2,195	3,432	24,881
Misc. (may include general laborer, service industry, and sex work)	183,155	22,508	37,711	243,374
TOTAL	610,106	104,789	99,352	814,247

Source: Office of Foreign Workers Administration, Department of Employment, Ministry of Labour, 2004

Occupational Safety

Migrants are rarely provided protective equipment or instruction on occupational safety, and thus, many migrant workers are ignorant of the benefits of protective gear.⁴ In metal shops

⁴ It should be noted that occupational safety standards in Thailand are generally low, and that this is not necessarily endemic solely to migrants, however, language barriers make accessing information on occupational safety standards even more difficult for migrants.

and small factories, migrants and Thais welding without proper eye protection is commonplace, accompanied by complaints of sore eyes and minor burns. Migrant laborers who work in orchards and plantations are often required to spray pesticides, yet no gas masks or training in proper application of pesticides is provided. Migrants working on plantations commonly suffer from skin diseases, respiratory problems and conjunctivitis. Eye irritations that become infected are also a common complaint. (ANM, 2004) On construction sites outside of Bangkok, hard-hats are rarely seen, and safety equipment is scarce. Generally, workers must purchase their own boots, gloves or other protective gear if they know to, or can afford to.

When there are accidents, migrants are rarely paid adequate compensation. A recently released report showed that construction is the most hazardous line of work in regards to accidents. The report says that Thai construction workers are nearly three times as likely to die at work and five times more likely to suffer permanent disabilities as those working in other hazardous jobs. Although the situation is getting better generally, accidents are still common in the informal sector, where migrants primarily work in construction; there are no official statistics available for this sector. (The Nation, April 29, 2005)

In Chiang Mai, one study showed that 88 percent of respondents, most of who worked in construction, had experienced an injury in the last six months. In another study, 69 percent of the male respondents working in construction had had a workplace injury within the last six months, and there were reports of deaths from accidents on construction sites. (Pinprateep, 2001) Sawmills and other factories that utilize heavy or dangerous machinery also pose grave dangers, with teenaged workers being especially vulnerable to injury. Migrants working in these types of factories have reported serious injuries as regular occurrences, including amputations and being struck by heavy falling objects such as logs or metal pipes. (Caouette et al., 2000; Koetsawang, 2001)

Only factories that receive ISO certification provide adequate safety or sanitation equipment. The gloves or protective garments that are provided, however, may make the wearer extremely hot and often cause rashes or abrasions that can become infected. ISO factories that hire mostly migrant laborers are rare. More commonly, migrants work in smaller, sub-contracted factories that do prep-work for larger ISO factories. These sub-contracted factories receive less scrutiny in regards to labor practices, and occupational safety and health standards; thus, migrant workers in these factories are more likely to be exposed to conditions that cause health problems. For example, migrants working as seafood processors regularly suffer skin irritation and infections related to having their hands submerged in cold, briny water for long periods of time without adequate protection. In garment factories at Mae Sot, there are reports of noxious fumes and high levels of dust without proper ventilation or facemasks, causing respiratory problems and irritations of the eyes and throat. (ANM, 2004)

Fatigue

Fatigue caused by excessive working hours in demanding conditions is a common occupational health condition among migrants in Thailand. Seafood processors, for example, regularly report suffering from fatigue. In Mahachai District in Samut Sakorn Province just southwest of Bangkok, there are approximately one thousand seafood-processing factories hiring over 100,000 migrant laborers, the majority of who are young women. Seafood processors start work at either 3 a.m. or 7 a.m. and, depending on the size of the shipment, may work up to eleven hours or more a day on average, mostly sorting and peeling shrimp (shrimp high-season lasts six months). They are not paid an hourly rate, but instead receive a

piece-rate according to the weight of shrimp peeled - a form of payment susceptible to rigged scales. Those who are adept at peeling can make 200 Baht or more a day (approx US\$5), whereas a more common wage is closer to 120 Baht (approx. US\$3).

Seafood processors in factories must work standing their whole shift because employers do not provide stools, and tables are required to be high off the ground for sanitation reasons. In most cases, workers are not provided with mandatory rest days, and days off need to be requested in advance. (ARCM, 2003) Main health complaints among seafood processors include headaches and muscle aches.⁵

Fatigue is also common among migrants working in the garment industry at the border town of Mae Sot in Tak Province, where over 150 garment factories are concentrated. These factories primarily rely on migrant laborers from Burma, some of whom cross the border daily. Garment factories, a considerable number of which are foreign owned, employ 1,000 to 5,000 workers per factory; the majority of laborers (almost 70 percent) are young unmarried females. (Fabel, 2001)

Many factories pay by a piece-rate system, and workers may only get one to two days off a month. It is reported that average days are ten hours long, with excessive overtime to fill orders as a regular occurrence. At one garment factory in Mae Sot in 2003, about 78 Burmese migrant workers who held work permits, mostly women, reported that they had worked an average of 15 hours a day, receiving just 90-100 Baht per day (less than US\$3), which included overtime. They stated that on one day they were forced to work over 24 hours under threat of dismissal. In a ceramics factory, also at Mae Sot, 119 young female migrant workers claimed that they often worked 16 hours a day, below minimum wage, with only seven Baht per hour for overtime. (Arnold, 2004)

Domestic workers also commonly suffer fatigue. Most domestic workers are young women who come primarily from Burma and Laos. Due to socio-cultural norms that create roles of authority based on gender and age, few domestic workers have the confidence to assert themselves to their employer. Since a standard contract of work is rarely if ever provided by the employer, work standards, such as breaks, number of hours worked a day, and days off, are left ambiguous. As the domestic setting tends to obscure the boundaries between work and personal time, domestic workers end up toiling endlessly, often working their whole waking day. Domestic workers start working at 7 a.m. and may not finish until 11 p.m. or later, depending on the workload that day, while only getting holidays and one day a month off. In addition to demanding work conditions, some domestic workers are only provided leftovers or cheap food to eat such as packaged noodles, or are only allowed to eat once the family is finished eating. (Caouette, 2001)

Fishermen are also known to work much of their waking hours, which includes working through the night. Fishermen are usually only granted shore leave a couple of days either once a month or every forty-five days, except for the largest boats which stay at sea for three to seven months up to a year at a time. Fishermen are given no safety equipment. Often they wear hats and long sleeve shirts to protect themselves from the sun, or a plastic poncho to protect from the rain. Fishermen are given no safety instruction, and there have been reports of severe injuries due to accidents on boats, some resulting in death. Some fishermen have

⁵ At an NGO clinic in Mahachai, for example, out of 532 clients seeking treatment over one month, 32% came to treat persistent headaches and 10% came for body aches: RTF/CARE 2004

mentioned suffering from “light-headedness and giddiness,” probably brought on from heat, fatigue, poor diet and motion sickness. (Tin, 2000) Recently, there was a report of a number of migrant fishermen from Burma being hospitalized for cardiovascular Beri-Beri, with some even dying. They had been on a boat at sea for seven months and ate only fish and rice without any fresh vegetables.

Sex Workers’ Vulnerability

Environmental hazards related to sex workers’ place of employment include music that may be played at excessively high volumes, causing hearing impairment, regular exposure to large amounts of cigarette smoke without proper ventilation, which may cause respiratory problems, and even improper electrical wiring that may result in electric shock. Many sex workers also complain of suffering fatigue and related symptoms. Sex workers are often forced to work more than ten hours a day with no breaks and only one or two days off a month. When they have not had enough rest, sex workers may suffer symptoms of fatigue, such as getting regular headaches or becoming sick easily. Women also report body aches from repetitive actions, such as giving massages, go-go dancing, performing sexual acts, and lifting heavy items such as crates of beer.

Sex workers who are migrants are commonly found in massage parlors and brothels - venues that tend to be inconspicuous or clandestine. Due to restrictions on mobility imposed by their employer and being unable to speak Thai, migrant sex workers, especially those who are undocumented, rarely leave their work premises, even to seek health care. As they are unable to access reproductive health information and services, migrant sex workers are unlikely to receive proper or any treatment for STIs, and they are susceptible to unplanned pregnancy, which is often accompanied by unsafe abortion. (See *Family Planning* section) (In areas where NGOs are actively working with migrant sex workers, access to health services has been increased considerably; however, coverage is limited to specific areas, and owners of sex establishments do not always provide NGOs access, especially when women are held under questionable circumstances.)

Although many sex workers have voluntarily entered sex work, while others have been deceived into it, once at their destination, many migrant women may lose control over their circumstances and their mobility when they find they are entrapped in a debt-bonded situation and their employer withholds their registration card. This type of scenario often occurs when the woman pays a broker either for transit into the country or to find work once in the country. In many cases, the woman may explicitly be entering sex work, and in other cases, she may be unaware of her destination. The owner of a sex establishment then pays the broker a fee higher than what the woman may have originally paid for transit. This amount is then deducted from the woman’s wages until the amount is paid back, which in many cases is hindered by unfair deductions for room and board and false accounting. This makes repayment a long process that forces the woman to take numerous customers. One Burmese woman reported that she had originally paid a 5,000 Baht fee for transport to a broker, but ended up paying 10,000 Baht to the owner by taking over 300 clients. (Bhumiprabhas, 2001) Although bonded-labor is not exclusive to sex workers, sex workers’ vulnerability to HIV/AIDS, especially migrants, increases with the number of clients she has over time as the potential for inconsistent condom use or breakage increases proportionately. (See “Condom Use” in the section on HIV/AIDS)

Living Conditions in Thailand

Many health problems are also related to migrants' living conditions. Generally, employers provide migrant workers with living quarters that they must pay rent for as part of the work arrangement. Generally, this arrangement is convenient for migrants, as they don't have to concern themselves with paying for transportation and being exposed in public, however in many cases this arrangement also leads to health problems. Employers who provide residence for their migrant workforce often charge exorbitant rates and skimp on the quality of the facilities provided. The limited accommodation and/or the cost of rent forces migrants, many with families, to live in overcrowded, unsanitary conditions with poor ventilation, where numerous people share a few toilets of poor quality, and may have limited access to clean water.

Water and Sanitation

Of the various occupations where migrants are prominent, construction sites, especially in the north, have some of the worst living conditions. The number of migrants living on construction sites in Chiang Mai, for example, may range anywhere from eight to twenty people on smaller sites, up to one hundred or more at larger sites. One site surveyed had over one hundred people including family members living together on the site with only a handful of toilets available. On many construction sites, the water provided for bathing and washing clothes is unsanitary, and often comes from a shallow well dug on the site that may collect the run-off from construction. A survey done in 2000 showed that 79 percent of respondents working in Chiang Mai, most of who worked on construction sites, had had a skin disease within six months of the interview. (Caouette et al, 2000) Migrants working and living on plantations and in orchards, also regularly end up with skin diseases from bathing in streams and other bodies of water where pesticide residual collects. (ANM, 2004)

Although there is generally a high level of access to potable water among migrant workers, access is dependent upon the type of work and the location of their residence. For those who do not have this access, gastro-intestinal problems may be common. Dysentery, for example, is common, especially on construction sites and among agricultural workers. Factories usually have the highest access to potable water, and plantations and construction sites the lowest. Drinking water is often provided when there is not tap water, but the cost is deducted from migrants' pay.

A survey in 2000 showed that 80 percent of adult respondents in Chiang Mai, many working in construction or agriculture, had had a bout of diarrhea or dysentery within six months prior to the interview. (Caouette, 2000) In 2001, another survey showed 47 percent of females and 59 percent of males from various Burmese ethnic groups working in different occupations and locations in Thailand had diarrhea in the past six months. (Pinprateep, 2001) In 2004, during a sample month at the NGO clinic in the industrial area of Mahachai, just eight percent of ailments treated were gastro-intestinal related. Nationally, acute diarrhea was the most common disease reported among migrant workers, with 6,270 cases reported in 2003 and 5,822 cases reported in 2004 (age of patients was not recorded). Provinces along the border of Burma that have refugee camps had the highest rates. (Bureau of Epidemiology, 2003-4)

Environmental Conditions

In factory dormitories at Mae Sot, reports of over-crowding and poor ventilation are common. Migrants have reported that some factories have seven to twenty people living in a three and a half square meter room without windows; whereas other factories have hundreds

of people living in rows of bunk beds in a single, open room on an upper floor of a dusty warehouse with only curtains separating them. (Fabel, 2001; ANM, 2004)

At Mahachai, over-crowding is also commonplace. Most rooms made for two people may house up to ten or more. If families stay together, they will often occupy the room with at least one other family; unmarried or single individuals of the same sex will board together, sometimes dividing the room between day and night work shifts. In such close quarters with poor ventilation, there is a greater chance for transmission of communicable diseases. The NGO clinic at Mahachai reported that in a sample month in January 2004, out of 532 clients seeking treatment, 14 percent sought treatment for respiratory tract infections, while another eight percent had ear/nose/throat problems. (RTF/CARE, 2004)

The lack of privacy and cramped or dirty living conditions, combined with their general circumstances, also causes stress. At the Mahachai NGO clinic, the primary complaint of those seeking basic services, almost 32 percent of clients (out of 532) reported suffering from psychological problems or stress, where in some cases this manifested as severe headaches. (RTF/CARE, 2004)

At construction sites, fishing ports, and slums, migrant communities are often exposed to effluent from industry or live over standing water, making them susceptible to flooding and mosquito-borne diseases, especially dengue fever. Agricultural workers live on plantations where they work, usually in ramshackle or makeshift houses located deep in the orchard, adjacent jungle or remote areas. Employers rarely provide migrant workers mosquito nets, leaving agricultural workers responsible for purchasing nets. Although many migrants are aware that sleeping under a net can prevent malaria, conditions of nets vary and may have holes. (In one interview, a family used the mosquito net to catch fish as well.) Many migrant communities are strewn with garbage due to a lack of sanitation services, ignorance on the part of migrants, or because they are located in an area used as a garbage dump. This unsanitary environment can increase the presence of mosquitoes and breed flies, leading to increased rates of disease.

The shelters where migrants stay, especially on construction sites and in slum areas, are often made of corrugated iron or scraps of metal such as garage doors and other discarded materials. These windowless shanties provide little protection from extreme heat and cold or other harsh weather conditions, and during the rain season, all their clothing remains damp, causing fungal growths and even vaginal candida. (Koetsawang, 2001)

Fishermen and Related Communities

Fishing boats have crews ranging in size from 3 to 40 men or more, depending on the type of boat. According to their size and function, boats go out to sea and return to shore either nightly, every three to five nights, ten to fifteen days, or three to six weeks depending on the size of the boat and the location of fishing waters. Some of the largest boats may stay at sea for six months up to a year at a time receiving supplies from transport boats, with some not returning to the port of origin for one to two years. (ARCM, 2003)

Fishermen's sleeping quarters are cramped, with men often lying side by side in rows. They eat what the captain provides, and are limited in their use of fresh water beyond drinking, limiting their ability to wash. They go to the toilet over the side of the deck. Although there are first aid kits on the boats, any illness or injury must wait until the boat returns to dock or

be transported by another boat before receiving proper treatment. There have even been reports of some boats having cases of dengue fever contracted on board.

Generally, depending on the size of the boat, fishermen are given two days of shore leave every thirty to forty-five days. When boats are docked in their port of origin, single men usually sleep on the boat, whereas married men will sleep on land with their family.

Living conditions at ports vary according to the level of industrialization of the port. In the less developed ports, migrant communities may live in wooden houses above tidal flats or adjacent the port (stilt houses use a hole in the boards as both a toilet and an escape hatch to evade police arrest). These communities are often located in marshy areas or are exposed directly to industrial fumes or effluent, garbage dumped overboard by boats, and refuse from the community. At more developed ports, ramshackle or dilapidated dormitories are provided where up to ten or more people, either a couple of families or a group of single-sex workers, share cramped, stuffy rooms. Commonly, these dwellings lack sufficient septic systems, which may be cracked and leaking. For these removed communities it is difficult to access health services unless services are in the immediate vicinity.

Women in Service Industries

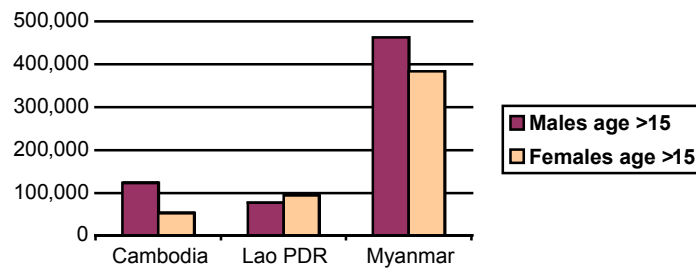
In karaoke bars, which have increasingly become a common venue for the sex industry, and in brothels, migrant sex workers will stay in the same location as their work. If it is a karaoke bar, the women will usually stay in the same room as the bar or an adjacent room where air quality is often stale from cigarette smoke, and in brothels it may be the same room where they provide services. Bathrooms, usually the same bathroom used by customers, are shared and are commonly in poor condition. At some of the residences where women work and live, the water provided is unclean, which may cause vaginal infections.

Domestic workers, who primarily come from Burma and Laos, also have precarious living situations related to the nature of their job. As their workplace is in the employer's home, these young women are at the mercy of their employer's temperament and good will. They live in the same quarters as the family that employs them, and are usually, except under the worst conditions, given a small room, which they may have to share with other servants. At night, the employer may lock the room from the outside.

Reproductive Health

Due to a lack of traditional social controls and being independent at a young age, adolescent migrants may have sex at an early age, making them susceptible to unplanned pregnancy, STIs and accompanying health problems. (Nopachai, 2004) Many migrant men are vulnerable to STIs due to their sexual behavior, especially certain sub-groups that practice risky behaviors such as fishermen. Due to almost negligible rates of condom use between spouses and intimate partners, this makes migrant women also highly vulnerable to STIs as well as a broad range of reproductive health problems that have serious health implications. Compounding this, migrant women have limited access to appropriate information and reproductive health services, further compromising their reproductive health.

Chart 1 - Distribution of Registered Migrant Workers over 15 Years by Sex and Nationality



Sexually Transmitted Infections

When clinics were located in Provincial Health Offices, few migrants were willing to utilize public STI services due to the location. Now, STI clinics are being integrated into hospitals as part of the government's consolidation process. The concern is that utilization rates may further decline due to shyness related to having to seek STI services at the same location as general health services. As it is, migrants who have STI symptoms will commonly resort to self-treatment, will remain untreated, or will go to a private clinic, which is expensive. This is concerning as it seems there are high rates of STI among migrants in Thailand.

For example, in 2002 at the Mae Tao Clinic in Mae Sot, there was a 2.7 percent prevalence rate of syphilis among migrants, many of who crossed the border from Burma into Thailand either as daily workers or simply to access health services. (Ekachai, 2003) According to the health exam for migrants in 2004, one-third of those with health conditions of concern had syphilis. (See *Health Exam* section)

In a study done in the year 2000 with migrants from Burma at Chiang Mai and Ranong, 21 percent of migrant women reported having had vaginal discharge that they didn't consider normal. In the same study, 30 percent of migrant men indicated that they had difficulty urinating. (Caouette, 2000) At Samut Sakhorn, seven percent of respondents had indicated having had an STI in the last six months, with symptoms of ulcers on the penis, discharge, puss and difficulty urinating. (Tin, 2000) In Rayong, where many Cambodian fishermen work, nine percent of health referrals for Cambodian migrants during the period of March 2001 to December 2002 were for STIs. (PROMDAN, 2003)

Family Planning

Family planning is highly problematic for migrants in Thailand and is complicated by numerous factors including cultural values. Although contraceptives are publicly available, migrants' access to and use of birth control methods are inconsistent due to various factors including language barriers, and low familiarity with contraceptives and their proper use. In some cases, cultural misunderstandings arise, causing women to discontinue or disrupt their family planning method. For example, among Burmese groups, menstruation is a sign of fertility, and if they don't understand that reduced menstruation is a side effect, they may discontinue their course. In addition, from numerous interviews, it is reported that Burmese groups prefer injections, as they believe all medicine is stronger when injected. However, if they are using injectables and are unable to access a clinic to get another shot after the three month period expires, they may be unaware that they are fertile again, resulting in unplanned pregnancy.

Sex workers in bonded-labor situations find themselves under highly restrictive and exploitative circumstances that affect their health, and limit control over their reproductive health. For example, it was reported that at the border in Ranong, Burmese sex workers were given injectable contraceptives by their employer so that the women wouldn't use condoms. Lacking familiarity with contraceptives and being at the mercy of the owners, many of the women weren't aware when they needed their next injection, which resulted in high pregnancy rates and unsafe abortions. (WVFT, 2003)

Unplanned pregnancy is one of the more common reproductive health issues among migrant women. Many migrants coming into Thailand to work are adolescents. With an absence of traditional social controls, and for reasons related to loneliness or personal security, they may have sex at an early age. Many of these young migrants have low knowledge about contraception methods, which results in high rates of unplanned pregnancies. At the Mae Tao Clinic for example, the proportion of teen pregnancies among Burmese migrants rose from 18.8 percent in the first half of 2000, to 26 percent in 2002. (Ekachai, 2003)

There are also high pregnancy rates among married couples. In Samut Sakhorn, 58 percent of married migrants from Burma indicated that they or their partner were not using contraceptives. (Tin, 2000) In Ranong, it was estimated that 15 percent of the migrant population, all from Burma, is under five years of age. (Fabel, 2001) At Mae Sot, a study showed that of those women interviewed who had sought reproductive health services, including inpatient care for post abortion related problems - one third had had five pregnancies or more. (Belton, 2003) In Rayong, it was reported that among married Cambodian women, approximately 60 percent didn't use any form of contraception, and most women became pregnant soon after marriage. It was estimated that there was a 17 percent rate of pregnancy among Cambodian women there. (PATH, 2003)

**Table 4 - General Registration of Migrants by:
Nationality, Age and Sex (2004)**

	Age	Male	Female	Total
Burma	0-11	33,271	29,883	63,154
	12-14	7,277	6,597	13,874
	15 and older	462,210	382,254	844,464
	Total	502,758	418,734	921,492
Cambodia	0-11	3,052	2,980	6,032
	12-14	895	922	1,817
	15 and older	122,535	53,157	175,692
	Total	126,482	57,059	183,541
Lao PDR	0-11	2,388	2,399	4,787
	12-14	991	2,427	3,418
	15 and older	76,720	94,962	171,682
	Total	80,099	99,788	179,887

Source: Office of Foreign Workers Administration, Department of Employment, Ministry of Labour, 2004

Delivery and Abortion

One study indicated that the frequency of migrants giving birth in a hospital versus at home with a Trained Birth Attendant (TBA) depends on factors related to that location, such as proximity to the border, availability of TBA and language considerations. In one study, 46 percent of respondents at Ranong reported giving birth using a TBA, whereas 94 percent of migrants in Chiang Mai reported delivering in a hospital or clinic. At Ranong, it was found that women who return to Burma to have a TBA assist with the birth preferred TBAs over hospitals due to language and cultural issues, lower cost, and sometimes because the migrant was undocumented. Ranong is also located directly at a porous border crossing with Burma, which makes it relatively easy to cross. In Chiang Mai, factors identified as influencing the high rate of migrant women giving birth in hospitals, included the considerations that hospitals are easy to access due to being in an urban area, migrants' ability to speak Thai is high, and there is a limited availability of traditional birth attendants. Moreover, Chiang Mai City is removed from the border area, which makes it harder to cross into Burma, and migrant women who are Shan are less likely to want to voluntarily cross back into Burma for fear of their safety. (Caouette, 2000)

Underlying health conditions affect the mother's health during and after delivery. Indicative of this, many migrants at both Ranong and Chiang Mai reported that there had been a high rate of complications during or after delivery, with 24 percent indicating serious problems, and 33 percent with very serious problems. (Caouette, 2000) There were 1,227 children delivered at Mae Tao Clinic in 2003, up from 783 the year before. (Mae Tao Clinic, 2004) At that clinic, it was reported that one third of normal deliveries had complications related to the woman previously having had an abortion. (Ekachai, 2003)

Due to the high rate of unplanned pregnancies and the threat of being laid off for being pregnant, abortion is a serious concern, especially among women from Burma who are prominent working in factories.⁶ In many cases, the woman will try to abort using unsafe methods prescribed or administered by traditional birth attendants, or on their own. At Mae Tao clinic in Mae Sot, 26 percent of IPD admissions and 10 percent of all Obstetric and Gynecological cases were related to post-abortion care. Out of 352 treated, 13 percent were between the ages of 15 and 20, and 26 percent had a prior history of abortion. (Mae Tao Clinic, 2004) In Mahachai, where numerous migrant women from Burma work in seafood processing factories, over 30 percent of migrant respondents indicated that they or their spouse had ever had an abortion, with most having had a self-induced abortion. (Tin, 2000) In Ranong and Chiang Mai, approximately 17 percent of respondents (99 out of 587) indicated that either they or their partners had had an unwanted pregnancy; and 55 percent of those had reported having an unsuccessful abortion or complications. (Caouette, 2000)

Of those having an abortion in Ranong, over 50 percent were self-induced with 25 percent through a midwife and only five percent through a health personnel; while in Chiang Mai, 72 percent crossed back into Burma for an abortion, with 60 percent being performed by a TBA, eight percent self-induced, and 28 percent by a health personnel. (Caouette, 2000) In another survey done in Ranong in 2003, over 40 percent of unwanted pregnancies were terminated through abortion, over 20 percent of those were self-induced and over 70 percent were done by a TBA. (Isarabhakdi, 2004)

⁶ Women from Burma constitute approximately 70 percent of the work force in the garment factories in Mae Sot area. (Arnold, 2004)

HIV/AIDS

Risk and Prevalence Rates

Generally, there is little available data on actual rates of HIV/AIDS among migrants in Thailand. As Thailand has been one of the foremost countries to feel the brunt of the AIDS epidemic, Thailand's government has adopted many progressive policies in regards to HIV/AIDS. Accordingly, the country has a policy that prohibits mandatory HIV testing for employees, even for migrant workers. There is HIV sero-surveillance that focuses on specific groups that are either at high risk of HIV/AIDS or represent a broader sample, including ANC clinics and STI patients, and certain occupations, such as fishermen and sex workers. However, there is no surveillance specifically for migrants, and the data on these groups does not disaggregate migrants from Thais, leaving uncertainty about actual HIV/AIDS prevalence rates among migrants.

There has been some HIV surveillance of migrant worker populations by local officials, although it has not been done on a regular basis, and sometimes may use unclear methodologies. In Samut Sakhorn Province in 2001, a surveillance sample among migrants from Burma indicated that 1.4 percent or 316 individuals had tested positive for HIV. (Bhumiprabhas, 2001) Rates of HIV among pregnant women testing at ANC clinics were recorded in some locations in 2001, with the general trend showing much higher rates among migrant women (see Table 5). At the Mae Tao Clinic in Tak Province, in 2003, out of the 2,435 pregnant women who tested for HIV through the ANC clinic, 35 women or 1.4 percent tested positive for HIV. (Mae Tao Clinic, 2004)

Table 5 – HIV Prevalence of Pregnant Women at ANC Clinics, 2001
(In provinces with sample sizes of 80 or more migrant women)

Province	Migrant Women		Thai Women	
	Total number tested	HIV prevalence (%)	Total number tested	HIV prevalence (%)
Trat	89	6.7 %	305	2%
Samut Sakhorn	93	4.3%	2,029	2%
Chiang Rai	467	2.4%	1,619	2.5%
Mae Hong Son	198	2.5%	238	0.4%
Ranong	102	0%	385	1%

Source: UNDP, 2004

A growing number of migrants are becoming educated about HIV/AIDS and can list the modes of transmission, and the fact that condoms can prevent transmission. Misconceptions are still common however, as is inconsistent condom. Although there are still some innocuous misconceptions, such as fears that HIV can be transmitted from a toilet or through mosquitoes, other misconceptions are less benign as they negatively influence condom use.

Occupations filled by migrants where risky behaviors are prominent include fishermen and sex workers. After being on a boat for long periods without sexual release, a practice enforced by superstitions, it is common for fishermen to band together, get drunk and visit sex workers during shore leave. Although drunkenness influences inconsistent or improper use of condoms, negative attitudes towards condoms, which are reinforced by uninformed beliefs about HIV/AIDS, play a greater role in inconsistent or low rates of condom use among migrant men. These negative attitudes and misinformation are prominent among migrants working as fishermen. Feelings that condoms are uncomfortable or unnatural are prominent among Mon men, and fishermen from Cambodia and Burma have been known to

base the decision of whether to use a condom on the belief that a sex worker's HIV status can be determined empirically by the temperature or color of her skin.

Some migrant fishermen have enhanced their penises by injecting hair oil or inserting glass beads under the foreskin, something that is done on boats as a bonding ritual, and under the misconception that it gives women pleasure. Unfortunately, these practices may considerably increase the risk of HIV transmission among fishermen and their partners, as penile implants make condoms fit improperly or break, cause abrasions in the vaginal walls of their partners, and may lead to infections in the penis.

Table 6 - Sample Rates of HIV among Fishermen, 2002-04*
(Migrants not separated from Thais)

Province	Primary Nationality of Migrants Present	2002	2003	2004
Chumporn	Burma	4.9%	0	9.4%
Pattani	Cambodia and Burma	4.5%	4.8%	4.5%
Phuket	Burma	9.3%	0	5.6%
Ranong	Burma	10.0%	6.5%	3.3%
Rayong	Cambodia, Laos and Burma	N/A	N/A	N/A
Songkhla	Burma and Cambodia	9.4%	9.8%	3.4%
Trad	Cambodia	2.2%	3.9%	N/A

Source: Ministry of Public Health, Disease Control Center Thailand: 2001-2004

**Note:* Sample sizes for fishermen are often small, making it unclear whether representative cross-samples are made up of different boats. Moreover, fishermen are highly mobile, which compromises the ability to show progression of prevalence rates over time, and instead simply gives a snapshot of prevalence.

At some large construction sites and factories where there are large numbers of migrant laborers, there are often karaoke bars right next door with young migrant women available. Rows of karaoke bars, coffee shops and the occasional brothel are commonly found at fishing ports, with migrant sex workers present to varying degrees depending on the geographic proximity to the border and the size of the migrant population. Generally, male migrant workers will seek out karaoke girls or sex workers who are of the same language group as they are in order to communicate more easily, but are also known to visit Thai sex workers as well.

Migrant women are more likely to work in the sex industry in high concentrations at border areas. Although surveillance by Thai authorities does not distinguish between Thai and migrant sex workers, rates of HIV found among sex workers at border provinces can provide a general indication of rates of HIV among migrant sex workers there. (See Table 7)

Table 7 - Rates of HIV Found among Direct and Indirect Sex Workers at Border Provinces, 2003-04

Province	Bordering Country	Direct Sex Workers 2003	Direct Sex Workers 2004	Indirect Sex Workers 2003	Indirect Sex Workers 2004
Ranong	Burma	25%	28.8%	4.0%	7.3%
Kanchanaburi	Burma	10.3%	6.9%	1.6%	4.1%
Tak	Burma	14.8%	4.0%	-	-
Chiang Mai	Burma	-	8.5%	1.7%	2.6%
Chiang Rai	Burma and Lao PDR	-	-	4.2%	4.0%
Nong Khai	Lao PDR	-	6.7%	-	-
Mukdahan	Lao PDR	-	-	3.7%	-
Srakaew	Cambodia	-	33.3%	-	3.5%
Trad	Cambodia	23.5%	38.7%	3.3%	6.6%

Source: Ministry of Public Health, Thailand: 2003-4

Condom Use

Limited access to condoms greatly contributes to inconsistent or low rates of condom use among migrants. When migrants are confined to their work areas or communities that are remote, it makes it difficult to access condoms unless they are provided by the employer or a health office, which is extremely rare. Currently, Public Health offices do not count migrants when procuring or distributing condoms, with the exception of sex workers. Thus, except for the efforts of NGOs in localized areas, migrants generally have low access to condoms.

Even when migrants do have access to condoms, one factor that compromises consistent condom use is issues of familiarity and trust (although this is not exclusive to migrants). Meeting women at indirect sex establishments, such as karaoke bars or coffee shops, may give men the impression that the women are not sex workers, while in many cases, the women working in these venues do not identify themselves in this way either. Issues of trust and intimacy then may override practical concerns, such as they or their partner's sexual history and previous condom use, resulting in low to inconsistent condom use. Regardless of the venue where they meet, even at a brothel, when a man goes to the same sex worker regularly, the couple may develop feelings for each other, potentially leading to reduced or no condom use.

Illustrating this, a survey of Cambodian fishermen in Pattani showed that 32 percent of respondents *never* used condoms with women from karaoke bars and coffee shops, and 14 percent *inconsistently* used condoms with these women (54 percent consistently used condoms); while with girlfriends, who may also be karaoke workers, 95 percent *never* used condoms. (RTF/CARE, 2002) In Ranong, migrant sex workers from Burma reported 84 percent average condom use with one-time clients, and 60 percent with regular clients. (Isarabhakdi, 2004)

Condom use with spouses is generally low among migrants (again, a phenomenon that is not specific to migrants). Surveys among migrants from Burma at a couple of different locations in Thailand found that around 95 percent of married women had *never* used condoms with their husbands, whereas around 92 percent of men had reported *never* using condoms with their wives. (Caouette, 2000; WVFT, 2003) At Samut Sakhorn, a rate of around 74 percent

was reported for *never* using condoms with a spouse. (Tin, 2000) (Rates of HIV among pregnant migrant women are presented in Table 5) Condom use is also generally low with girl/boy friends, with around 85 percent reporting that they never use condoms. (RTF/CARE, 2002; WVFT, 2003) Although less reported, wives of fishermen have been known to have affairs with other men while their husbands are gone for long periods. It is unknown how common condom use is among these groups; however, it is assumed that since this type of relationship is based on intimacy, condom use would be low.

Considering these low rates of usage among married couples, a major factor in the spouse's vulnerability to HIV is the question of whether married men and women use condoms consistently if, and when, they have sex outside of their relationship. In the border town of Ranong, 42 percent of all male respondents reported *always* using a condom with sex workers, while 91 percent of men surveyed in Chiang Mai reported they *always* used condoms with sex workers. (Caouette, 2000) At Phuket, migrants from Burma working as fishermen reported less than 30 percent condom use in their last experience with a migrant direct sex worker, and less than 18 percent condom use in their last experience with an indirect migrant sex worker. With Thai sex workers, 74 percent of the men reported using a condom the last time they had sex, whereas only 58 percent reported using condoms consistently with Thai sex workers. (WVFT, 2003) Cambodian fishermen in Pattani reported that of those who went to brothels, 12 percent used condoms *sometimes* while 22 percent *never* used condoms (the rest used condoms regularly). (RTF/CARE, 2002)

Migrant sex workers' vulnerability to HIV/AIDS increases when they lack accurate information, are unable to access condoms, or lose the power to negotiate for safer sex. Sex workers' access to condoms is problematic if owners are reluctant to provide condoms on the premises because they feel that it acts as incriminating evidence that there is commercial sex available, which is illegal. Language barriers are another factor in HIV vulnerability, as their ability to learn about condoms or potentially negotiate condom use with clients is diminished if they are not of the same language group. If a migrant sex worker is in a situation where there is coercion, threat or force by her employer, including being undocumented, then her ability to negotiate for condom use may be further diminished. Moreover, if a woman is required to take numerous customers in one day (such as when they are under a debt-bonded situation) and is not provided lubricant, condoms may cause chaffing, resulting in condom breakage or women taking condoms off their customers due to discomfort. At the border in Ranong, for example, migrant sex workers indicated that they could have over 70 one-time paying clients, and possibly 40 regular paying clients in one month. (Isarabhakdi, 2004)

Migrants Living with HIV/AIDS

A persistent cough or wasting is one of the signs that many migrants assume indicates AIDS. Those PLHA (People Living With HIV/AIDS) who have families with them are reportedly taken care of by family members; those without family often suffer alone, and may eventually die alone. Some migrant PLHAs have wanted to go home to die as their last wish, and if they are lucky, find assistance from NGOs to do so. Others have been repatriated through formal systems, but only make it as far as the border, where they find they are not strong enough to make the trip home, and instead remain at the border until they pass away. At the border in Sangklaburi, there is a safe house for migrants who are either affected with severe diseases or are recovering. The safe house reported that half of the severe cases they receive have died there, and that most of those people had advanced stages of AIDS.

Although migrants with symptomatic HIV/AIDS are supposedly able to receive palliative care at hospitals, the ability of migrants to actually receive these services is confounded by issues of documentation and payment. Moreover, ARV treatment (ART) at subsidized cost is not available to migrants, making ARVs prohibitively expensive for migrant workers. Although ARV for prevention of mother to child transmission (PMTCT) is supposedly available to all pregnant mothers, including migrants, actual numbers of migrant women in this program are low. Moreover, once the child is delivered, neither the migrant mother nor the child is currently eligible for ART at a subsidized price. Complicating issues of PMTCT is the fact that VCT is only available in Thai language unless an NGO or trained volunteer assists in translation.

Some of Thai Public Health's policies concerning voluntary testing, notification and confidentiality regarding HIV/AIDS are ethically questionable. For example, HIV testing is mandatory for all women (Thais and migrants) who request services at the ANC clinic. Considering that health providers are known to treat migrants with bias and even disdain for treatment of general conditions, and even Thai PLHAs complain about health personnel's insensitivity, there is concern that health providers may not adhere to proper guidelines in situations concerning migrants with HIV/AIDS.

For example, when a migrant comes in with apparent symptoms of HIV/AIDS or is tested in accordance to other procedures, such as for the ANC clinic or having an operation, the option of having full knowledge regarding their HIV status is not always provided due to language barriers. In Chiang Mai, for example, there was a report of a Lahu woman who had tested positive for HIV and had just delivered a child; she was simply told to give her baby powdered milk because her milk was not strong – there was no mention of HIV or any other counseling provided. At Rayong, a Cambodian admitted as an inpatient was suffering a complication with an internal organ related to AIDS. Although the doctors knew the man's HIV status, they did not approach the man about his underlying condition. (As reported anecdotally from field interviews)

There have also been concerns over returning migrants with HIV to their home countries for fear of suffering discrimination and stigma. The worst-case scenario is Burma, where there have been reports of returning migrants being tested and segregated, and those with HIV being held temporarily in camps or hospitals. Such incidents raise serious ethical concerns about policies on returning migrants, especially as relates to issues of HIV/AIDS.

Moreover, there is little available in the way of care and support in migrants' home countries, especially in rural areas, due to limitations in the capacity and resources of medical providers. ARVs are currently not available in these countries either, and there are reports of PLHA coming from Lao P.D.R. over to Thailand to receive treatment at private clinics at the border. (CARE, 2004) Although there is discussion about migrants in Thailand having access to ARVs through the health insurance scheme, and the Thai government has promised to assist neighboring countries in accessing ARVs, neither of these policies have been supported or approved by the Thai government yet.

Increasing tolerance and decreased stigma of PLHAs is the goal of many AIDS related programs in Cambodia, Lao P.D.R. and Burma. Regardless of the success of these activities, shame is still a prominent feeling experienced by migrant PLHAs, making some unwilling to return home. For example, it is reported by NGOs at the border in Cambodia that many returning migrants who are suffering from AIDS may not return home, but will simply cross

the border and stay at communities there. In Poipet, a district at the main border crossing with Thailand, the community has a prominent presence of PLHAs who were previously migrants. (Press, 2004)

Malaria and TB

Many migrants that cross the border in remote areas to avoid police and border officials may be exposed to malaria. Some may start experiencing symptoms once they are already at their destination – a serious consideration for fishermen who may suffer symptoms once they are at sea. Those working in remote areas on plantations are also highly susceptible to malaria. Due to their remote location, issues of documentation and transportation often play a factor in accessing services, and results in delaying treatment.

The highest rates of malaria as well as the most drug-resistant strains of malaria have been found along the border with Burma. Many migrants try to self-treat as a first recourse, and only seek treatment once symptoms have become severe, which sometimes may be too late. In the Mae Sot Hospital at the border with Burma in Tak Province, case fatality rate for malaria among migrant patients was 3.7 percent in the year 2000, whereas it was 0.8 percent for local Thais. During that year in Mae Sot, half of the patients in malaria clinics were from Burma, where 14,226 people were treated for severe malaria. (Fabel, 2001) In 2003, the Mae Tao Clinic reported 4,599 cases of malaria, with 1,397 of them requiring inpatient treatment.

In surveys of migrants from Burma in 2000 and 2001, an average of close to 55 percent of respondents had had malaria in the past six months while they were in Thailand. Of this group, men had a higher occurrence than women, and those in northern provinces had a higher rate than those in the south. (Caouette, 2000; Prinateep, 2001)

TB has also been problematic in Thailand and is especially prominent among migrants. According to estimates derived from the health exam for registration in 2004, over 9 percent of migrants tested may have TB. (See Table 2) Many cases of TB in Thailand are a symptom of HIV. Based on the Thai general population, there are estimates that around 14 percent of new TB cases throughout the country are a symptom of HIV. (Bureau of Epidemiology, 2003) In the year 2004, at the River Kwai TB Hospital at the border in Sangklaburi, 16 percent of new TB patients admitted were infected with HIV, all of who were migrants. In Tak Province in the year 2003, the Mae Tao Clinic at Mae Sot referred 578 people with suspected cases of TB to MSF's chest clinic. (Mae Tao Clinic, 2004)

TB treatment is especially problematic among migrants due to restrictions on time availability imposed by work, issues of high mobility and documentation, limiting the success of DOTS treatment for migrants through hospitals. In Ranong in the year 2000, a cure rate of 54 percent for TB treatment had been reported among migrants, while in 2002, to provide comparison, there was a cure rate of 57 percent reported among the general population in Ranong, which included migrants. (Fabel, 2001) Along the border with Burma, default rates on treatment for TB in 2002, including Thais, migrants and ethnic hill tribes, was on average almost 14 percent, with the highest default rates being 20 percent in Tak province, and 18 percent at Prechuab Khiri Khan in the south – both of which are provinces bordering Burma. (Bureau of Epidemiology, 2003)

Barriers to Health Services for Migrants

Although registered migrants are supposedly entitled to the same health services as Thais, the access and level of care available for migrants is clearly not the same. Partially due to administrative issues, such as a lack of initiatives, and mostly due to practical factors, including the lack of a functioning model for migrant health compounded by public health's capacity, migrants' ability to receive the full benefit of public health services is limited.

Limited Access

As part of the registration in 2004, the Thai government required all migrants requesting work permits to purchase health insurance. The policy also allowed all registered migrants, including unemployed migrants, family members and dependents, inclusion under the Thai Universal Coverage System. As mentioned previously, this system provides treatment for the majority of health problems under a flat fee of 30 Baht per service. For coverage under this scheme, migrants are required to take the health exam, which costs 600 Baht per person, and then they must pay a fee of 1,300 Baht for the insurance. Unlike the work permit, there is only one fee rate. Although employers forward money for their employees to pay these fees, which is then deducted from their wages, the expense is a financial burden for most migrants. As a result, only limited numbers of those without employers, and only a fraction of family members or dependents have obtained health insurance.

Migrants who have purchased insurance and are thus covered under the 30 Baht scheme find that the location of providers frustrates their ability to conveniently access services. One consideration is that, like Thais, migrants can only receive the flat 30 Baht fee at the sole health provider assigned to them. The location of this assigned provider in relation to a migrant's place of work or residence may be inconvenient or far away, adding the complication and expense of transportation. As service hours usually coincide with work hours, migrants must also sacrifice time from work, which is accompanied by a deduction from their wages. Some migrants are registered at border areas under the "colored card" system. If these migrants move to another part of the country, they are unable to use their health insurance card in the new location. Mobile occupations also suffer the same problem, most notably fishermen, who are assigned to a provider at their port of origin, which they may return to only periodically.

Considerations of ID

Another issue that impinges upon the ability to fully receive benefits granted through the health insurance scheme is the fact that many employers withhold migrants' ID cards, giving migrants an insubstantial photocopy, as a way to ensure that they don't leave or change employers. Without their ID cards, migrants are subject to arrest and are unable to receive the benefits of their health insurance. This effectively restricts migrants' freedom of movement and makes migrants reliant upon the employer to provide transportation, or to allow them to seek treatment in the first place.

There is also uncertainty on the part of health providers as to what the legality is of providing services to undocumented migrants. It is clear that all health providers are bound

by duty to provide emergency health services to all people, including undocumented migrants. What is unclear to health providers is whether they are obligated to report undocumented migrants to the police once they have been treated.

Barriers of Culture and Language

Most migrants who have had experience with the public health system have generally had a negative one. Oftentimes, migrants receive half-hearted attention and condescending attitudes from health providers. Language barriers make understanding registration systems difficult, frustrating health providers' already limited patience in dealing with migrants. Sometimes an employer or a friend who can speak Thai will accompany migrants to overcome language barriers, and some hospitals utilize a set of migrant volunteers developed through NGOs for translation. Migrants who do not have this luxury may have difficulty explaining their symptoms, possibly resulting in an incomplete diagnosis and improper or inadequate treatment. This all but obviates meaningful counseling on complicated issues such as VCT or PMTCT. The language issue may take on even more weight as public STI clinics are now being incorporated into hospitals.

Language is only one component of the cultural understanding that complicates proper health treatment though. Due to a lack of knowledge about physiology and informed by cultural understanding, migrants may inaccurately attribute some symptoms to the wrong organ - such as women who may describe pains in their uterus as a stomachache, or toothaches that are simply described as a headache. Cultural beliefs may also compromise treatment. People from Burma, for example, believe that injections are the most effective form of treatment and may pursue an injection from a "quack" doctor in the community if not given one at the hospital. In the use of female contraceptives, a strong value is placed on menstruation as an indicator of fertility, thus, if side effects such as a diminished menses are not clearly explained, a woman may interrupt her course, possibly resulting in pregnancy.

Factors that limit migrants' access to health services

- Language and cultural barriers to proper treatment (explaining symptoms or receiving instructions on treatment)
- Regulations of health insurance to obtain flat fee of 30 Baht, such as the requirement of going to "assigned health providers," may not be explained to migrants or may be confusing
- Assigned health service providers (to obtain flat fee of 30 Baht) may be inconvenient to reach or far away, adding the expense and arrangement of transportation
- Time of service provision by health providers may conflict with working hours of migrants
- Many employers keep migrants' ID cards as a form of "insurance," restricting migrants' mobility and making them reliant on their employers to receive the health insurance they have paid for
- Fear of arrest deters some migrants, especially those who are undocumented
- Negative attitudes of health providers towards migrants makes migrants reluctant to seek treatment from public service providers

Administrative Issues Affecting Health Services for Migrants

Beyond the palpable barriers migrants experience in accessing public health services, there are administrative issues that frustrate health providers' ability to adequately provide services to migrants. Policies that dictate the way budgets for the provision of health services for migrants are garnered, structured and used have bewildered and frustrated many local health providers.

The way that budgets are used is a major factor underlying local providers' provision of health services for migrants, especially in light of the budgetary strains caused by the 30 Baht scheme. The origin of the problem is that all directives on migrant health are made at the National Level, without feedback mechanisms from local health providers. The result is that, unable to clarify ambiguities or uncertainties, local health administrators will tend to err on the side of caution.

The budget for health services to migrants that local health providers use is garnered directly from the fee migrants pay for health insurance. As of 2004, the fee migrants paid per person was 1,300 Baht, which was collected during registration. Those funds are then allocated back to local health providers according to the number of migrants registered at that location, divided into the following budgets:

Out of the 1,300 Baht paid by each migrant

1) Treatment receives 964 Baht

- Health insurance group (centralized) = 50 Baht
- Health facility where the migrant is registered = 914 Baht:
 - ☞ outpatient = 499 Baht
 - ☞ inpatient = 415 Baht

2) Disease prevention / health promotion receives 206 Baht

- Provincial Health Office and Dept of Medicine

3) Administrative receives 130 Baht

- Provincial Health Office and Dept of Medicine = 120 Baht
- Dept of Health Services Support (central government) = 10 Baht

During the 2004 registration, health insurance payments by migrants generated **1.06 billion Baht** (almost \$28 million US). Of this, **168 million Baht** (over \$4 million US) is dedicated to disease prevention and health promotion.

Prevention

Unfortunately, it seems that many health managers don't understand that these finances do not come from the government's budget, but from fees paid directly by migrants. As most administrators lack a clear understanding about the origin and use of these funds, in the face of uncertainty, they prefer to demonstrate fiscal responsibility by *not* spending the money. Moreover, few health facilities that provide services for migrants are even aware there is a 'health promotion' budget available for migrant health-promotion activities, and, sadly, some provinces have not used this money at all. In these cases, there should be large monetary reserves sitting untouched, supposedly earmarked for migrant health.

Many health providers laboring under the 30 Baht system are already overloaded providing services to the Thai public, making provision of services to migrants seem like an added

burden to their work. In addition, the limited amount of health-promotion outreach for Thai citizens makes outreach for migrants that much less likely. Except for occasional vaccination campaigns and activities to prevent outbreaks of mosquito borne diseases, there is a paucity of preventative services provided specifically for migrants. Moreover, it has been reported that condom procurement and distribution by Provincial Health Offices is based on calculations of the Thai population and numbers of sex establishments, and that in most Provinces, this calculation does not include migrant populations.

Hospitals serving migrant populations have indicated that hiring migrant health assistants would be of great benefit in health promotion, and some hospitals are utilizing migrant volunteers developed in collaboration with NGOs. The problem is that budgets do not explicitly support this sort of hiring, and, currently, policy does not allow the employment of migrants by the government. Although some providers have attempted developing print materials in the language of migrants, oftentimes these materials have been poorly translated, used language that is too complicated, or included images that do not relate to the intended target beneficiaries. Recently, in some locations, health officials are collaborating with NGOs in developing printed health materials.

Treatment

On the other hand, use of the ‘treatment’ portion of the budget is limited to reimbursing services for only documented migrants. There are no mechanisms to compensate debts incurred for service provision to uninsured migrants by transferring leftover funds from the budget for insured migrants. Thus, many hospitals must absorb the treatment costs of uninsured migrants by using their savings, even if there is a surplus in the treatment budget for insured migrants. (PATH, 2004) This is especially problematic for health providers at the border with Burma.

Table 8 - Highest Costs Incurred for Providing Healthcare to Migrants in 2003

Province	Insured / documented (paid by insurance)	Uninsured / undocumented (drawn from savings)
<i>Nationwide</i>	<i>94.7 mil. Baht</i>	<i>226.5 mil. Baht</i>
Tak Province	8.5 mil. Baht	36.7 mil. Baht
Chiang Mai	6.7 mil. Baht	4.8 mil. Baht
Kanchanaburi	2.4 mil. Baht	6.7 mil. Baht

Source: The Nation, June 8, 2004

Health Services for Migrants

In response to the variety of barriers that limit the quality and access of public health services for migrants, it seems that migrants have a “hierarchy of preference” for services. This hierarchy of preference is influenced by a variety of factors, including: price, convenience, cultural familiarity and considerations of language.

In many cases, traditional healers and herbal remedies are the first choice of treatment for minor ailments. These are inexpensive, familiar and easy to access - ranging from herbal remedies to “cupping” and running coins over the body. Next in preference is to self-medicate. This often involves taking leftover medication from a friend, going to a pharmacist

or even having a friend going and explaining symptoms second-hand to a pharmacist. This is especially common for treating symptoms related to STIs. In some communities, there are “quacks” and midwives that provide injections, which are strongly preferred among migrants from Burma.

Private clinics, including NGO clinics, are the next line of preference for more serious conditions. Even though private clinics are expensive and may have limited services, the convenience of location and not having to worry about showing registration cards or deal with bureaucracy make clinics an appealing health service option for migrants. Hospitals are generally the last resort except for services that are only provided in hospitals, such as ANC clinics. Even though the fixed rate of 30 Baht included as part of health insurance is linked to local hospitals, migrants are either unaware of this or are reluctant to go.

NGO clinics are highly regarded by migrants because services are usually provided in migrants’ language, clinics are conveniently located in or near migrant communities, and services are inexpensive. Running a clinic is a complex undertaking, and thus, there are only a few, and the set of services they provide are limited. Clinics are only one component in the strategies NGOs in Thailand are employing to improve migrants’ access to health services. Currently, NGOs are using two strategies to improve migrants’ access to health: in the first, the NGO is the service provider; in the second, Public Health is the provider with NGOs acting as a linkage.

NGOs as Service Provider

Generally, NGO health clinics for migrants work independent of, but in collaboration with, Public Health. Most of these clinics are located at the Burmese border, but not all.

Along the Border

The most famous NGO clinic is the Mae Tao Clinic in Mae Sot, Tak Province. Mae Tao Clinic was established by Dr. Cynthia Maung in 1989, and has been providing health services to migrants from Burma since. Those coming for health services include migrants already living and working in Thailand and those crossing the border from Burma specifically for services; the latter constitute approximately one-third of the clinic’s clients.

In 2003, the clinic recorded 82,801 consultations, an increase of its caseload from the previous year by 40 percent. Of those, 32,644 were medical and child outpatient services, while 3,791 were inpatient cases, of which 36 percent were malarial cases. Another 5,847 cases were surgical, with the majority being non-trauma related and dental.

The Mae Tao Clinic has Burmese and international physicians, up to ten at any one time, who, with the assistance of 86 intern health workers and 150 medical, administrative and logistical staff, provide comprehensive care. The clinic provides a gamut of services including: outpatient and preventative health, which includes vaccines; inpatient care, which includes surgery, malaria and TB wards; reproductive health services, which includes ANC, childbirth, mother and child health, PMTCT (Prevention of Mother to Child Transmission of HIV), family planning, STI and VCT (Voluntary Counseling and Testing) services; and also provides a range of specialized services including eye care and a prosthetics workshop.

Mae Tao Clinic also provides regular trainings to support those in the community who support health including: Traditional Birth Attendants, on-going training of health workers and attendants at the clinic, the Back Pack Health Team for IDPs (Internally Displaced

Persons) in Burma, and health assistants at two different refugee camps. There is also an intern program at the local Thai hospital that allows health workers from the clinic to work side-by-side with Thai doctors. Other collaborations with Public Health and the Mae Sot Hospital include vaccination programs, PMTCT, surgical and obstetrical referrals, and medical waste disposal.

Other organizations that provide direct services at the border mainly work with refugees, but many of these organizations have recently expanded health services to those immediately surrounding and directly related to camps. Medicines Sans Frontier (MSF) serves Karen refugees living in camps in Mae Sot and Ratchaburi and Mon people living outside camps along the Thailand- Burma border, providing medical care, including treatment of tuberculosis and provision of Anti-Retroviral Treatment (ART). In Mae Sot, MSF runs a tuberculosis program for migrant workers from Burma. The project has a chest clinic with a lab, treatment facilities run by six medical and lab staff, supported by six highly active outreach staff that follow up DOTS patients daily at their residence to ensure treatment compliance. Even with the high investment of staff time into follow-up, there was a success rate of 70 percent. Although this rate is lower than WHO standards of 85 percent, it is much higher than the local hospital's success rate of 55 percent (2002 rates). In 2004, the MSF TB clinic treated 250 migrants.

International Rescue Committee (IRC) also has a health project for migrants outside of refugee camps in Tak Province. IRC recognized that many of the people living and working outside of the camps in this area come from the same villages as those in the camps. Those outside the camps, however, have less access to health services and live in unsanitary environmental conditions, resulting in poor health. To address this, the IRC has trained over 40 health volunteers in ten migrant communities, set up five community health posts, as well as built water systems and latrines in these communities. As part of the project, the Ministry of Public Health, in cooperation with the IOM, is providing training for these volunteers. Volunteers will assist in basic preventative health as well as referral to public health facilities and will help distribute educational materials on communicable diseases such as TB, malaria, HIV/AIDS, and child vaccinations. (IRC, 2004)

Other organizations providing health along the border, mostly in camps but with an increasing emphasis on related populations outside camps, include: American Rescue Committee (ARC), Aide Medicale Internationale (which also produces Health Messenger Magazine, to support health workers from Burma), Malteser Germany, and Border Action Against Malaria. There are also numerous small NGOs and CBO (Community Based Organizations) that provide a mix of services, including safe houses and orphanages. One such NGO is Social Action for Women (SAW). This group provides mobile clinic services with a focus on women and children, provides temporary shelter for women in need, and assists with community capacity-building.

Away from the Border

World Vision Foundation of Thailand (WVFT) is an international NGO that provides health services directly to migrants. WVFT's clinics are part of health related activities that focus on migrants in fishing communities in four contiguous southern provinces: Chumpon, Ranong, PhangNga and Phuket, two of which border Burma. WVFT's clinics mainly provide preventative health with a focus on reproductive health and syndromic management of STIs.

Through a partnership with the Ministry of Public Health, WVFT's clinics are officially designated health centers. This means that they are incorporated into the health system and thus receive a certain level of support for medicines as well as recognition by the government of being legitimate health providers. The relationship WVFT has with Public Health also allows Burmese doctors to work at the clinics. WVFT now has three clinics, one at Ranong - the original location that has been operational for over ten years, as well as recently opened clinics in Phuket and Chumpon. Numerous trained volunteers, called Community Health Volunteers (CHV), support these clinics by promoting general and reproductive health in migrant communities. CHV provide family planning and HIV prevention related activities, referral services to WVFT clinics and public health facilities, as well as distribute condoms through social marketing.

Raks Thai Foundation (RTF), also known as CARE Thailand, has had a reproductive health clinic in Mahachai District of Samut Sakorn Province for over six years, located adjacent a large migrant community that works in seafood processing. The RTF clinic utilizes outreach as part of its strategy, including regular mobile clinics that are supported by a network of volunteers in the communities who help promote the mobile clinics and provide referral and follow-up of cases. The clinic, not officially a health center, is staffed with a medical doctor and health assistants from Burma, and provides limited services, primarily family planning consultations and some general preventative and curative health. The Provincial Hospital and many of the private hospitals give the clinic its informal blessing, as these services lighten their load of serving migrants, which is significant considering that this province has the largest migrant population of any province not located along the border. There is also an active partnership with the Provincial Hospital, where medical staff accompanies RTF's mobile clinic on a weekly basis and the hospital purchases medicines for the clinic.

To the Border

Although migrant PHA can be found in migrant communities, very few get the opportunity to receive ARV treatment. Some PHAs encountered receive care and support from NGOs or health volunteers, yet in many cases migrant PHAs simply wish to return home. World Vision is one NGO that assists PHA migrants to return home. Being an international NGO, WVFT is linked to World Vision in Myanmar (Burma). As part of their programming, World Vision works on both sides of the border crossing at Ranong-Kawthoung, which enables World Vision staff to provide coordinated referral services to help PHA migrants cross the border there safely, and accompany them home once inside Burma. Recently, Pattanarak Foundation and Raks Thai Foundation have developed an informal referral system to assist ill migrants return safely to the Burma border from Samut Sakorn and Samut Songkram Provinces in Thailand.

Some migrants who have been sent to the border, but who are ill with advanced AIDS or other debilitating diseases, such as TB, malaria or mental illness end up remaining at the border. At the border in Sangklaburi, three organizations, the River Kwai Christian Hospital, the "Safe House," and Pattanarak Foundation, are working together informally to take care of migrants in this predicament. Often encountered wandering aimlessly on the road or hiding in the forest, trying to avoid returning home without knowing what else to do, locals often assist in referring infirm migrants to the "safe house." The safe house, which receives support from the Burma Border Consortium, provides temporary shelter for migrants who are infirm or recovering and have no place to stay. A high percentage of individuals arrive very sick with many suffering advanced AIDS, and approximately fifty percent of those who

are physically infirm die from their maladies. Those who do stay, especially PHA, receive food assistance from Pattanarak Foundation in collaboration with the safe house.

Migrants who are not terminal are referred to the River Kwai Christian Hospital, where they receive treatment. The hospital has a TB ward and specializes in treatment of malaria. Migrant patients who have recovered enough to leave the hospital but perhaps still need treatment, such as TB patients, or simply are too weak to return home, are referred back to the safe house. Although these organizations are not able to assist migrants in crossing the border, they do provide necessary care and support for migrants who wish to return home but are only strong enough to make it to the border.

Indirect Provision of Health

Referral and Outreach

Referral is another strategy used by NGOs to assist migrants in accessing health services. Referral services by NGOs often provide transportation to overcome problems associated with documentation, expense, or complications with transport drivers and police. NGO referral also assists with translation to explain symptoms and treatment, as well as to navigate complicated registration and payment systems. Some NGO staff provide referral assistance directly, but most NGOs develop and train networks of volunteers in the communities to provide or assist in the referral process.

Referral systems take many forms. Some NGOs use drop-in centers as a focal point for arranging trips to the doctor. In Chiang Mai, referral for STI testing and treatment for migrant sex workers is provided by Empower Foundation, departing from their drop-in center on a specified day each month. Empower's referral system includes using registration cards stamped with the organization's logo as a way of ensuring that protocols agreed upon through negotiations with the Provincial Health Office, such as not requiring ID, are adhered to by clinic staff. Center for AIDS Rights (CAR) in Rayong and Chonburi works primarily with Cambodian fishermen, and provides referral for both general health and STI treatment. Other NGOs using drop-in centers as a point for referral services include Stella Maris, and Raks Thai Foundation.

MAP Foundation in Chiang Mai uses a dispatch system, where a migrant will call the office's crisis center requesting referral assistance, and MAP will then call a volunteer closest to that person to assist. World Vision Foundation Thailand is one of the organizations that trains its volunteers to be completely self-reliant, where volunteers can provide referral to migrants independently, and migrants know how to contact these volunteers directly because they are members of the communities they serve.

Many NGOs are partnering with local health offices to provide outreach services for migrants. Health officers that have initiatives and funds to provide services to migrants but are unable to access migrant communities have been approaching NGOs to act as a linkage to migrant communities. These partnerships have resulted in mobile clinics and vaccination campaigns, which have been highly successful.

Many NGOs have developed numerous communication materials (IEC/BCC) on specific health conditions such as malaria, TB, HIV/AIDS, STIs, mother and child health, as well as rights issues including the right to health in the various languages of migrants. The types of

materials are diverse, ranging from brochures and pamphlets, to storybooks, posters of different types, audiocassettes and CDs, radio broadcasts, and even video. The strength of these materials is that they are developed with direct participation and feedback by the target beneficiaries, ensuring that the information, language and images used in the materials are appropriate to that group.

Developing Migrant Health Systems

Currently there is one project funded by the Global Fund to Fight AIDS, TB and Malaria that is specifically focused on migrants. The Prevention of HIV/AIDS Among Migrant Workers in Thailand Project (PHAMIT) is a collaborative project among eight NGOs and the Ministry of Health's Department of Health Services Support and Department of Disease Control. Raks Thai Foundation, the Principal Recipient, works with PATH, WVFT, MAP Foundation, CAR, Empower, Stella Maris and Pattanarak Foundation to provide HIV/AIDS prevention and health related activities in over twenty provinces throughout Thailand. The project's objectives include: increasing condom use and reproductive health practices among migrant workers and related populations, making the health system more accessible and suitable for migrants, supporting community development and environmental health, and promoting a political atmosphere that supports migrant workers' rights.

The majority of activities in the PHAMIT project includes: outreach, developing volunteer networks, distribution of condoms and contraceptives, production and distribution of IEC/BCC materials, referral systems, partnerships with health providers, and community support such as education for migrant children. In addition, one of the more potentially lasting aspirations of the PHAMIT project is to develop and integrate a "Migrant Health System" into the currently existing health system. PATH is the lead organization on this mission in the PHAMIT project, and is working with the Department of Health Services Support and Public Health Offices from seven provinces that have significant migrant populations. So far, this component has identified many of the logistical and administrative issues that complicate health delivery to migrants (as mentioned in this study), and is now working to identify systems that could be put into place to address these gaps, including the training and formal registration of migrant health assistants.

In a similar vein, the International Organization for Migration (IOM) is also currently working with the Ministry of Public Health in two provinces to develop a health system that will act as a replicable model for improving migrants' access to health services. This project, similar to others, develops and utilizes a network of Community Health Workers (CHW) from the migrant community to provide outreach activities, develop communication materials and create a linkage for referral. What is different about this project is that the network of health volunteers, or CHWs, falls under the supervision of either the District Hospital or the District Health Office, depending on the location with an IOM Field Coordinator providing technical advice and managerial support. Sensitivity training for Thai health service providers and environmental health are also part of the project's objectives.

The World Health Organization (WHO) in Thailand, although not an implementing agency, works to promote health along the Thai-Burma border. Some of its coordinating activities include an annual Border Health Meeting that brings together PHOs and NGOs from border provinces, and providing the MOPH with capacity building in data collection and coordination. WHO has also assisted the MOPH in the translation of the "pink book," used by the Thai Public Health System to track a child's development, into Burmese and Thai for migrant parents to use to maintain continuity in vaccination schedules in case the family

crosses back into Burma. (In a separate project, PATH assisted in the development of a similar “yellow book” for Cambodian migrants.)

UNFPA is also supporting the Thai government to develop functional relationship with its neighboring countries to improve health at the borders. There are currently cross-border coordination committees at six “twin-city” border sites around the country, even though there have been difficulties in establishing this model at border sites with Burma. These provincial and local level committees share health information and data with their counterparts on the other side of the border as part of these meetings.

Emotional Well-Being of Migrants

Emotional and Psychological Health / Verbal, Physical and Sexual Abuse

The overall emotional state and psychological well being of migrants in Thailand is poor, as indicated by high rates of self-reporting of stress and related symptoms. Migrants’ work environment, living conditions and tenuous political status weigh on their emotions and cause psychological stress. Working long hours under stressful conditions, constantly worrying about being able to make and save money, and fearing police arrest also leads to stress, anxiety and depression among migrants. On top of that, employers may heap verbal and even physical abuse, summed up by one woman’s sentiments, “have you ever been cursed at so badly you wanted to cry?” (Rajanaphruk, 2001)

Some migrants find ways to relax, such as going to temple or church, cooking traditional foods, playing sports, or consulting traditional healers. Often, those who suffer anxiety and stress may vent in self-destructive ways by using drugs and alcohol, and through violence, including domestic abuse. In some fishing ports where migrant fishermen are prominent, there are reports by NGOs of fierce fighting among drunken fishermen, sometimes even resulting in deaths. Although not studied extensively and not openly discussed, women have indicated that domestic abuse is common among migrants, and is often fueled by alcohol consumption. Women may end up being beaten severely by their husbands, forcing them to make a difficult choice of the uncertainty and insecurity of separating and, in many cases, becoming a single, working, migrant mother, versus the certainty of what staying together brings. (Caouette, 2000)

One study that interviewed migrants from Burma in two different parts of Thailand showed that 89 percent, or 506 respondents, had experienced stress/depression/anxiety in the past six months. (Caouette, 2000) In another study that interviewed migrants from different ethnicities from Burma of varying ages and various occupations around the country, showed that 51 percent of females (424 individuals) and 73 percent of men (397 individuals) had experienced stress/depression/anxiety in the last six months. Using peptic ulcers as an indicator of stress - 28 percent of female respondents (419 individuals), and 32 percent of male respondents (383 individuals) in the same study had experienced a peptic ulcer in the last six months. (Pinprateep, 2001)

Adolescent migrants find themselves in a new and uncertain social context that they must navigate on their own, and many will seek out a boyfriend or girlfriend due to loneliness. Some women indicated that they have sought a partner and even married for personal security. (Caouette, 2000) Youth may also start drinking alcohol, smoking and taking drugs

at an early age either to cope with stress, to fit in, or because there are no social constraints on such behaviors.

Control over Money

Some migrants may chose to quit their job because of the physical toll it was taking or due to exhaustion or abuse, only to have their whole salary, which usually includes back-wages, withheld by their employers under the excuse that they had “broken their contract.” Sex workers, factory and construction workers, fishermen and any other occupations where the employer provides residence, food or water, commonly have the cost of these expenses deducted from their pay at exaggerated rates. Wages are usually so low that there is hardly anything left after deductions, leaving migrant workers staring into an endless cycle of zero-gain. (Caouette; Wai; Koetsawang)

The difficulty migrants have in controlling their money, the original reason they migrated in the first place, creates terrible stress. Many migrants have been able to make and save money, but as they are generally unable to secure their money through means such as bank accounts or such, they must keep their money at their residence or on their person, leaving them vulnerable to theft and extortion. Many migrants report that they have had money stolen, sometimes by other migrant workers or by Thais in the vicinity; but the most common report is of police taking money, either in raids on their work place and living quarters, or en route home. (Caouette, 2000; Koetsawang 2001)

“He held our cards in his left hand, with the other he searched our belongings...He searched my bag...We had packed our clothes there and hid the money in the trouser pockets...The policeman didn’t say anything while taking four thousand seven hundred baht from a pocket. He held it in his hand and searched our bodies...then he found another four thousand in my husband’s shirt. That was all of our money. The policeman smiled and left the room, just like that...” - Migrant Woman from Burma (Koetsawang, 2001, p.141)

Reverberations from Home

The stress of family separation has also weighed on migrants’ emotions, as arrests and deportations leave both parties uncertain as to the other’s fate. Most are able to simply turn around and re-enter the country, but some are not reunited due to circumstances beyond their control, making women and children in these situations especially vulnerable. (Koetsawang, 2001)

Of those who have families in their home country, men are more likely than women to migrate for work and leave their spouse and children back home. Among Cambodian fishermen in one study, 38 percent had a wife at their home community, and among fishermen from Burma in a separate study, 20 percent had a wife at their home community. (RTF/CARE, 2002; Tin, 2001)

Some fishermen from Cambodia reported that they were ashamed to contact or even return home until they had been able to save or remit a significant amount of money. Unfortunately, because they lack a location to safely save money, and may end up using the money for drinking and commercial sex, many fishermen are unable to successfully save or remit very much money. Thus, they put off communicating back home until they get paid again. This creates a vicious cycle that leaves many Cambodian fishermen out of contact with their families for years, wallowing in a state of shame. (PROMDAN, 2002)

Returning to their home country to visit families can also create stress, as possible arrest or harassment by police on the Thai side or by officials in their home country is a realistic fear that weighs heavily. In Lao PDR, migrants may be fined for having left their district without notifying the government, and in one province, it was declared by the provincial government that it was prohibited for anyone to cross the border to work in Thailand. (CARE, 2004) Shan people from Burma, especially women, are extremely reluctant to return home due to fear of persecution and violence at the hands of the military.⁷ (Caouette, 2000)

Many of those coming from Burma may already suffer from depression due to the political conditions that forced them out of their homes, while some still experience high levels of anxiety as a lasting repercussion of the violence at the hands of the military. Some women from Burma, most notably Shan women, have indicated that the sight of Thai police arouses fear and anxiety in them, as the site of uniformed men with guns reminds them of the Burmese military.

Many migrant women have reported being raped by their employers, with a high incidence among domestic workers. These women may then become desperate to leave their current location, potentially leading them into the hands of brokers who may place them in worse circumstances, such as in a brothel. There have also been reports of police incarcerating and gang-raping women on their way back to the border of Burma. It is reported that a number of women who have suffered this fate have ended up catatonic, or have taken their lives through suicide. (Caouette, 2001; Koetsawang, 2001)

Physical Violence, Confinement, and Rape

There are reports of fishermen being threatened, beaten and even killed at sea - their bodies dumped overboard. There are also cases of male migrant workers at ports and factories being beaten by Thai thugs hired by employers; some beatings have even resulted in death. Often these are retaliatory beatings for migrants who have asserted themselves in some way, either requesting their full wages, refusing to take the blame for a Thai person's mistake, or simply walking out and refusing to bear another tirade. (Wai, 2004) There was a high profile incident in February 2002, when fourteen migrants (seven men, seven women) suspected to be of Karen ethnicity from Burma, were killed and found dead in a river at the border province of Tak. It was suspected that their boss murdered them to avoid payment for work. (The Nation, Feb 2, 2002) Reports of migrants being summarily killed and dumped are common in Tak Province, with one incident where the bodies were burnt to conceal evidence. (Bangkok Post, May 27, 2003)

“One of my friends died here too. He was sitting there and was simply shot. No news anywhere. No police investigation. It’s so easy to die.” - Migrant Woman from Burma (Koetsawang, 2001, p.136)

According to anecdotal information from NGOs in sending countries, the age that girls leave home and migrate for work in Thailand has progressively gotten younger (it should be noted that many young Shan women are fleeing for their safety). Many of these young women have just become teenagers, and are leaving home for the first time. Due to their naiveté, having had little exposure to anything but village life or possibly learning about Thailand from TV shows, some of these young women may fall under the influence of brokers or end

⁷ “Licence to Rape” by the Shan Women’s Action Network (SWAN) catalogues the Burmese military’s use of sexual violence against Shan women in the on-going war in Shan State through first-hand accounts.

up working behind closed doors as domestic workers in the homes of rich and influential people, or in small sweatshop-type factories. Once they find themselves in the confinement of the work place, they are vulnerable to being forced to work excessive hours without receiving adequate wages, if they receive any wage at all, and their employers may even beat or rape them. In September 2004, seventeen Laotian girls between the ages of eleven and fourteen were found locked in a secret, windowless chamber in a jeans sweatshop in the Bangkok area. They reportedly lived in slave-like conditions where they worked eighteen hour days, were poorly fed, beaten and hadn't received wages in six months. (The Nation, September 16, 2004)

In accounts of abuse against young workers, four young women ranging in age from 13 to 16, with one boy who was 14 years old, reported having been beaten or repeatedly abused by their employers. All of the girls bore scars or bruises from beatings with sticks, sharp objects or shoes, some had been scalded or burned as well. According to social workers and NGOs working to protect women and children, young migrant women working in domestic households tend to suffer high rates of abuse. (Bangkok Post, Aug 7, 2003) As testimony to this, just recently a high-profile story came to light where a Thai woman beat her 17-year-old maid, who was Karen from Burma. The girl was beaten so badly that her head needed a metal plate, and she was hospitalized with on-going operations for two months to repair her broken back and shattered ribs. (The Nation, April 30, 2005)

Rape

Rape is a common occurrence among migrant women, and is highly underreported, with very few cases ever making it to the courts. In many cases, police officers, immigration officials or employers are the perpetrators. These men are often in influential positions and wield political power with the means to divert the law or physically dispose of the claimant by having them killed. There have been reports of border police pulling migrant women from Burma off buses and keeping them confined and raping them. (Caouette, 2001; Koetsawang, 2001) Some police may keep Burmese women as sex slaves while they are incarcerated. (Wai, 2004) There are also reports of police acting as brokers for migrant women between sites in Thailand or into sex establishments, who have raped young women in their charge. (Won, 1999)

Domestic workers are at a high risk of rape or sexual abuse at the hands of men in the household due to their confinement within the employer's home. Migrant women who have been raped by locals in the community also find it hard to report their abuse for fear of reprisals and difficulties in accessing the legal system. When migrant women who have been raped are undocumented or have been trafficked, they are often afraid to seek help from the officials; and in some cases, those who have sought redress have ended up being deported as "illegal migrants" rather than being defendants in a rape case. Recently though, NGOs have been providing legal assistance to see that these cases are pursued. Although this has provided greater access to the justice system, it has not guaranteed the impartiality of the law.

Incarceration and Deportation

Arrest or police harassment is also commonplace among migrants in Thailand. Although this seems an inherent part of many migrants' lives, the health effects of incarceration and deportation, although easy to anticipate, have not been assessed.

One study showed that 50 percent of men and 27 percent of women interviewed had been arrested over the course of the previous year, with men who were arrested in Chiang Mai having been arrested on average 1.6 times that year. (Caouette, 2000) Often, the main complaint is that cells are hot, small and overcrowded with reports of people fainting without room to lie down. In many cases, cells are so overcrowded that migrants must sleep upright. (Koetsawang, 2001) In Samut Sakhorn jail, it was estimated that the cell for Burmese was 20'x30' with two hundred people. There was one fan of 14" placed outside of the cell. It was reported that over thirty people a day were suffering from dizziness and getting sick from the heat and conditions. (Wai, 2004)

Food is often of poor quality and portions are small. On top of that, gangs of Thai prisoners, often in cooperation with the police, extort exorbitant fees from Burmese prisoners for food, clean water, cigarettes and a place to sleep. There have even been reports of people dying from starvation or lack of water under these circumstances because they had run out of money. Gangs often beat migrant prisoners as well, forcing them to give up clothing and other possessions, or simply to harass and humiliate them.

Those who have been incarcerated have mentioned that it has a weakening effect on them, and requires time to physically recover. In a source community in Cambodia, wives of migrant workers reported that one of the impacts of migration on their husbands was that they returned in a weakened state from exhaustion and incarceration. (PROMDAN, 2002)

"After I came out of prison, I was weak and did not want to do anything." - Shan man, age 24, Chiang Mai (Caouette, 2000, pg. 106)

In many cases of arrest, migrants that are registered but whose employer has kept their ID are detained until the employer can be contacted. Sometimes, this results in migrants spending weeks in jail, and when they are released, the fee for release is usually deducted from the migrant's pay. If the employer does not come or does not pay the fine, then they may be sent to court and imprisoned or deported. Often arrest of migrants is a ruse used by employers so that they do not have to pay back wages, where the employer is the one who reports undocumented migrants in the first place.

The Dangers of Deportation

Undocumented workers arrested face three months in jail and/or fines of up to 5,000 Baht. Upon completing their sentence, they are then repatriated, which also harbors dangers. In one incident in early 2004, a transport truck carrying 107 migrant workers to be repatriated to Burma including family members and four children, overturned on the way to the border in Kanchanaburi Province, killing seven and injuring over fifty migrants. Although hospitalized, no compensation was provided to those injured. (The Irrawady, 2004) Similar incidents occur regularly, periodically showing up in the news.

When deported, Thai authorities rarely ask Burmese migrants which border crossing they wish to be sent to for repatriation and generally send them to the closest border. Some migrants may end up at a place that makes it very difficult to return to their home. Those who are of ethnic groups being persecuted may be put in a politically perilous situation if facing the Burmese military, possibly resulting in arrest or even death. Some migrants have even been deposited at the border of the wrong country. Due to similarities in language and facial characteristics, some Cambodians have been incorrectly identified as being Mon and have been left at Sangklaburi – the border with Burma.

Most deportees simply turn right back around and re-enter the country when they can. Brokers at the border, some of who are police, benefit greatly from this arrangement. It is estimated that 10,000 migrants are being deported to Burma every month, and that in the year 2003, over the course of nine months, 96,296 migrants from Burma had been sent through the Mae Sot border alone (The Nation, Oct 5, 2003). Over the course of that whole year, 106,597 illegal workers from Burma, Cambodia and Laos were arrested and deported in total. (The Nation, May 24, 2004)

(Lack of) Rights in Time of Disaster

The tsunami that devastated coastal Asia starkly illustrated migrants' tenuous status in Thailand. When the waves struck, many migrants along the Andaman coast lost their identification papers, their jobs, and family members. The tsunami devastated their lives; then a second wave of misery descended. Without proper identification, migrants became susceptible to exploitation, arrest and deportation. The Thai media put out inflammatory stories that Burmese migrants were looting, resulting in a massive crackdown. In all, at least 675 migrants were officially reported as having been repatriated and many others reportedly sent without going through official channels. At least 40 others have been in detention, and an estimated 2,500 or more migrants returned to Burma independently. Unbeknownst to those migrants, leaving the area where they registered or crossing the border automatically nullified their registration status. Many of those that returned to Burma on their own had lost family members, or indicated that they were in shock and needed to rest. In other cases, many migrants, some who were still traumatized, stayed and worked in order to repair boats and related businesses as fast as they could under their employers' promises of payment or threats of violence.

In the first days after the tsunami hit, although minor accounts of discrimination were reported, migrants received basic relief and health treatment for wounds at camps and temples; around twenty migrants were hospitalized. Once the crackdown began, though, migrants were turned out from camps. Many avoided police by fleeing to hilltops, or hiding in plantations and construction sites; many others sought refuge in migrant communities at other locales. At these locations, survivors relied on friends, relations, employers and NGOs to provide food, water and shelter. In many cases, there was concern that migrants were not receiving proper nutrition or were suffering from dehydration. For example, food supplies in migrant communities, which were already limited, became stretched by the influx of people; employers who sheltered migrants provided the most basic of rations, and relief efforts by NGOs were hampered by migrants' high mobility and the remote locations where they took refuge. New mothers and young children faced the gravest health threats, including some new mothers found to be unable to produce adequate breast milk for their babies. Albeit there were minor cases of disease, there were no major outbreaks as was feared at the outset.

The mental health impact of the tsunami on migrants has been tremendous. Some traumatized survivors were unable to sleep for days afterwards, while others refused to descend from their mountain refuge or even look at the ocean. Many others were left in a state of shock by having been suddenly displaced and becoming refugees, or having been separated from loved ones without any way of being reunited or knowing what became of them. It is estimated that at the minimum, 1,000 migrants were killed, with high-end estimates ranging from 2,500 to over 4,000. In the morgue, over 3,000 bodies of Asian ethnicity have been left unidentified, of which it is estimated by authorities that 2,000 may be migrants. For those migrants who recognized dead bodies of relatives after the water had

receded, there was the strain of knowing that their body had been recovered, yet, due to fear of arrest, they were unable to enter the compound, identify the body or provide proper services. Through the assistance of the Tsunami Action Group (TAG), a considerable number of migrant communities have received religious commemoration ceremonies with Burmese monks for the dead and missing. TAG also assisted in the re-issuing of missing ID cards, however, due to bureaucratic glitches and an unwieldy database, by March 2005, only around 200 IDs had been re-issued for migrants. MSF Belgium has also been providing essential health and relief services to displaced migrants. (TAG, 2005) (ANM, 2005)
TAG website - www.saydanatsunami.org

Conclusion

What becomes obvious from assessing health problems of migrants is the fact that a primary condition undermining migrant health is not necessarily access to health, although that is a factor, but conditions related to their daily life. Although migrants' access to health services is relatively low compared to Thais, with assistance from NGOs and willing public health providers, there are strides being made to increase migrants' access to appropriate health services. The Ministry of Health, especially at Provincial levels, has been showing positive signs that the development of a workable "migrant health system" is at hand. Whether problems related to funding and decentralization can be overcome to support such a system, however, remains to be seen.

The reality is that migrant health will not be improved solely by increased access to services. Health is a holistic condition that is also promoted or compromised by environmental factors and levels of sanitation. Health is also greatly influenced by other, less tangible factors such as emotional well-being, a sense of personal control and security, freedom of movement and adequate rest, for example. These factors then impinge upon a basic sense of control over an individual's life, making the implications of contracting AIDS in the future seem insignificant compared to a migrant's daily struggle. With a diminished sense of personal value or a reduced sense of personal control, individuals may be more willing to take risks as they feel a sense of abandon or fatalism, which may negatively affect their sense of self-preservation, including their vigilance in preventing AIDS.

Without the ability to fully access basic labor and human rights, or health services and information in their own language, migrants' status as a marginalized population will continue to undermine migrants' health in Thailand, and will increase their vulnerability to HIV/AIDS and other reproductive health problems. Only through migrant policies that aim for greater inclusiveness, and allow migrants increased access to rights mechanisms with

meaningful enforcement and a greater sense of community, will an appreciable difference in migrants' health be made in Thailand.

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