Assessment of Mobility and HIV Vulnerability among Myanmar Migrant Sex Workers and Factory Workers in Mae Sot District, Tak Province, Thailand

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As the leading intergovernmental organization for migration, IOM acts with its partners in the international community to assist in meeting the growing operational challenges of migration management; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
GMS	Greater Mekong Subregion
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
INGO	International Non-governmental Organization
IOM	International Organization for Migration
IPSR	Institute for Population and Social Research, Mahidol University
MOPH	Ministry of Public Health
NGO	Non-governmental Organization
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand
PPS	Probability Proportionate to Size
RTG	Royal Thai Government
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY……………………………………………………… 1

2. BACKGROUND………………………………………………………………… 4

3. INTRODUCTION…………………………………………………………….. 5

4. METHODOLOGY AND CONSTRAINTS………………………………….. 10

5. FINDINGS…………………………………………………………………….. 15

  SEX WORKERS……………………………………………………………….. 15

    MIGRATION……………………………………………………………………. 15

    EMPLOYMENT…………………………………………………………… 18

    BEHAVIOR…………………………………………………………………... 21

    HEALTH……………………………………………………………………… 25

  FACTORY WORKERS……………………………………………………... 27

    GENERAL CHARACTERISTICS AND MIGRANT DEMOGRAPHICS.. 27

    MIGRATION……………………………………………………………………. 28

    EMPLOYMENT…………………………………………………………… 32

    HEALTH AND BEHAVIOR……………………………………………… 36

6. RECOMMENDATIONS……………………………………………………… 46

ENDNOTES…………………………………………………………………... 53

1. EXECUTIVE SUMMARY

Funded by the UNAIDS Thailand Country Office's Programme Acceleration Funds (PAF), developed jointly with the World Health Organization (WHO) and implemented by the International Organization for Migration (IOM) Bangkok Regional Office, this assessment examines mobility and HIV vulnerability among Myanmar migrants in Mae Sot District, Tak Province, Thailand. Environmental and social factors, service access, knowledge, and behavioural vulnerabilities, along with gender issues, stigma and discrimination, are addressed.

Undertaken from December 2005 through April 2006, this assessment aims to assist the Royal Thai Government (RTG) and partners to develop more effective policies and programmes for preventing HIV transmission, and to improve access to HIV and AIDS treatment and care among selected Myanmar migrants.

The assessment team employed a collaborative qualitative and quantitative research approach to assess HIV vulnerability among migrant sex workers and migrant factory workers. A total of six focus group discussions were conducted with both direct and indirect sex workers, while six and four focus group discussions were conducted with male and female factory workers respectively. Eight individual interviews with direct and indirect sex workers were completed. Key informants and gatekeepers were consulted and snowball sampling was used to establish the appropriate groups or individuals for interview. The quantitative component of the assessment was designed using probability proportionate to size (PPS) sampling methodology, and a pre-tested questionnaire was consequently administered to 819 migrant factory workers between the ages of 15 and 49 in 12 factories in Mae Sot District. There were 312 male and 507 female respondents, all of Myanmar origin.

Through the research, the assessment team learned that migrants arrive in Thailand with little or no knowledge about HIV/AIDS and sexual health, and in some cases basic knowledge of reproductive health. Though training and outreach programmes have reached some of the factory worker and sex worker populations, knowledge remains at a very basic level and is predominantly disseminated by friends and siblings who attended various trainings. The qualitative and quantitative findings show that most of those demonstrating some knowledge of HIV/AIDS were merely reiterating what was disseminated during the outreach. Important knowledge and some behavioural gaps persist.

From as far as Sagaing in central Myanmar to just across the bridge in Myawaddy, migrants working at the factories of Mae Sot District are from diverse areas within Myanmar. The largest numbers, however, are from Mawlamyaing and Bago in Kayin State, in the eastern region of Myanmar.

The driving forces behind the migration of the predominantly rural Myanmar population to Mae Sot District include financial difficulties back home due to debt, death or sickness, and the hope for a better life in the future.

Some of those who arrive in Myawaddy are brought to the Thai side of the border through the employment of "carriers" or brokers (commonly referred to as *gae-ri* in Bamar or *nai nah* in Thai), who offer migrants job placement opportunities that would otherwise be almost impossible to achieve without a contact. Under such schemes, female migrants are particularly vulnerable to exploitation. There is evidence to suggest that brokers provide the initial capital for the women to migrate to Thailand and then sell them to a karaoke bar or brothel. The women are then bound to work off the amount of money that was paid by the brothel to the broker.

Though factory work is certainly the most sought after type of employment, it is not consistently available. Many migrants are forced to wait several months for positions or find other endeavours as day labourers, farmhands, construction workers or housemaids, or simply return home.

The ultimate goal for the majority of migrants working in Thailand is to accumulate enough capital to eventually return home to family and friends and use that capital for commercial pursuits. Should such pursuits fail, the individual often considers returning to Thailand.

Sex workers are vulnerable to HIV primarily due to the high risk of their profession. Indirect sex workers (those working out of a karaoke bar, restaurant or freelance) are particularly vulnerable because information and services do not reach them. Conversely, factory workers demonstrated little vulnerability to HIV due to their sparse amount of free time, restriction of movement outside the factory compound, lack of extramarital sex, conservative social values and lack of disposable income. Their lack of knowledge with respect to HIV/AIDS and sexual health, however, creates some vulnerability. These findings could be confirmed by results from studies in other provinces/countries with migrants from other countries such as Lao PDR.

Efforts need to be increased to provide culturally appropriate HIV/AIDS and sexually transmitted infection (STI) information to migrants, using strategies that facilitate analysis of personal risk perception. Health-care providers require improved sensitivity to the basic needs of migrants, including respect for confidentiality in the clinical setting.

The importance of the public sector in providing STI, HIV and reproductive health services to migrants cannot be overemphasized. Migrants express a clear preference for STI treatment in the public health sector because they can better remain anonymous in the clinical Thai setting. Many direct sex workers (brothel-based sex workers) are already assisted through regular check-ups at Mae Sot General Hospital. Factory workers and sex workers involved in the study trust government health-care providers over non-governmental organizations (NGOs) and community-based organizations. Great impact can be made by strengthening collaboration between government health-care providers and both the private sector and the migrants themselves. Migrant community health workers working under the direction of the health authorities can be an effective mechanism (e.g., the IOM-Ministry of Public Health [MOPH] Migrant Health

Programme model). Sensitivity, confidentiality and communication skills of public sector health-care providers should be strengthened for improved impact.

Moreover, existing programmes (e.g., the hospital's STI clinic) could be strengthened to ensure that migrants receive appropriate referral to an array of government and NGO services locally available. During the study it was clear that the agencies working on HIV-related programmes are neither communicating regularly nor cooperating effectively with one another. A strengthened coordination mechanism is warranted wherein government, NGO, and private sector stakeholders can improve transparency, share materials and information, strengthen referral networks and create improved working relationships.

Although the study faced several obstacles, particularly regarding issues on access to targeted populations which affected the representativeness of the study sampling, the research team had used the best of their knowledge and skills in minimizing the study bias. It is the hope of the assessment team that the information contained within this study will assist in informing policy makers and implementers in improving STIs/HIV programmes for migrants in Mae Sot District and elsewhere in Thailand.

2. BACKGROUND

Millions of people are on the move in the world today, where economic, political and social circumstances are the predominant reasons for migration. The phenomenon of mobility creates channels where information, culture and disease travel from one place to another. Due to a lack of up to date and accurate information on migrant vulnerability to HIV infection along the Thai-Myanmar border, this assessment was carried out under the direction and supervision of the IOM Migrant Health Programme supported by UNAIDS PAF 2004/2005.

After planning sessions and fact finding field visits to Mae Sot District, factory workers and sex workers were chosen for this study based on:

1) their perceived level of risk and vulnerability to HIV/AIDS;
2) the large number of migrants in Mae Sot District;
3) the declining use of condoms among commercial sex workers[1]; and
4) the general lack of knowledge and information available on perceptions, vulnerability and understanding of HIV/AIDS among migrant sex workers and factory workers.

The objective of the study was to identify HIV/AIDS related knowledge, attitudes, beliefs and practices, as well as the social, structural, economic and psychological factors leading to HIV risk and vulnerability among sex workers and factory workers from Myanmar. This assessment provides information that will enable the Royal Thai Government (RTG) and partners to develop more effective policies to prevent HIV transmission and improve access to HIV/AIDS treatment and care among migrants.

IOM aims to develop HIV/AIDS programming that will empower migrants to take control of their health by equipping them with knowledge and skills to protect themselves from STIs/HIV. Other project activities include identifying prevention mechanisms, providing educational materials on reproductive and sexual health, and enabling access to condoms and to STI/HIV/AIDS counselling and testing. Through the Migrant Health Programme, IOM works to improve health service access for migrants from Myanmar in partnership with the MOPH and other agencies at the central and local levels.

IOM's Approach to Health

IOM's approach to migrant health is both rights based and gender sensitive in its focus on trans-border health concerns. IOM believes in developing sustainable migration health systems that improve the day to day living conditions of migrants. Through its HIV/AIDS programmes, IOM works to improve the understanding of HIV/AIDS and reduce the stigma and discrimination that are often associated with migration and with the disease.

3. INTRODUCTION

In recent years, Thailand has become the most developed country in the Greater Mekong Subregion (GMS), offering more employment opportunities and higher wages than any of its neighbours. Significant economic disparity can be demonstrated by comparing Thailand's per capita gross domestic product (GDP) to that of Cambodia, Lao PDR and Myanmar. In 2005, Thailand's per capita GDP was US$ 8,300, compared to Cambodia's of US$ 2,200, Lao PDR's of US$ 1,900 and Myanmar's of US$ 1,700.[2]

In addition, Thailand's economy is growing at the fastest rate in the GMS. This growth rate would not have been sustainable without migrant workers, and economic growth continues to make Thailand a main destination country for migrant workers from Cambodia, Lao PDR and Myanmar. Thailand currently hosts an estimated 2.5 million migrants, approximately half of which are documented. Most of the migrants come from Myanmar (75%) followed by Cambodia and Lao PDR. As of September 2005, there were about 1,284,920 migrants registered with the Thai Ministry of Interior.[3] The table below outlines the distribution of migrants in Thailand by nationality and region.[4]

Table 1. Migrants in Thailand

Region	Myanmar	Lao PDR	Cambodia	Total
Bangkok	127,716	53,642	26,284	207,642
Central region	202,679	35,964	39,887	278,530
Eastern region	39,302	20,989	91,073	151,364
Northern region	252,036	8,064	1,331	261,431
Northeastern region	5,299	48,329	3,865	57,493
Southern region	207,096	9,852	16,080	233,028
Western region	71,753	4,774	3,059	79,586

Source: IOM 2004. *Number of Border Migrants Registered by Region and Nationality*. IOM Labour Migration Statistics, Thailand. (http://www.iomseasia.org/index.php?module=pagesetter&func=viewpub&tid=6&pid=316)

In addition to the registered and unregistered migrants currently in Thailand, there are approximately 140,000 displaced persons in camps along the border with Myanmar.[5]

Migration to Thailand

IOM defines mobile persons as individuals who move from one location to another temporarily, seasonally or permanently either voluntarily or involuntarily. Each year millions of individuals are "pushed" and "pulled" away from their families, homes and countries in search of an improved quality of life and a more promising future. The migration story involves a plethora of complex human circumstances. Most individuals who migrate do not anticipate the mix of adverse conditions they will face at their destinations.

Factors that "pull" or attract migrants into Thailand usually include higher wages and more abundant employment opportunities while factors that "push" migrants into Thailand are poverty, unemployment and low wages. In addition, migration is often facilitated through sets of informal interpersonal linkages in origin and destination countries, often kinship and friendship. In fact, most migrants to Thailand migrate

through a variety of assistances and services provided by their relatives or friends in many phases of their mobility.

Migrants in Thailand contribute to economic growth by performing undesirable jobs in the sectors of agriculture, domestic services, fishing and construction for lower wages than Thai nationals would demand. Migrants' jobs are avoided, if not shunned, by the local Thai population due to the poor working conditions and low wages. Despite the low wages, employment in Thailand is still more lucrative for migrants than working in their countries of origin. Near the Thai border, a 45-year-old male health worker in Mon State, Myanmar said:

> "*Those who come back say if you work for one year here you can't even save enough to build a bamboo hut, whereas if you work in Thailand for one year, it is possible to build a proper house. Look at that house [he points to a brick house with a zinc roof]. I do not know what job they did in Thailand, but they were able to build a proper house. The owner of that house went to Thailand for five years. Some people come back for good once they have saved enough*."[6]

In addition, migrants' tolerance level of poor working and living conditions is high due to the poverty they face at home, their limited options for gainful employment, and the fact that few are aware of, understand or are able to defend their rights.

Registration Process for Migrant Workers

Since 1996, the RTG has implemented registration policies that promote the documentation and regularization of foreign workers from Cambodia, Lao PDR and Myanmar. In 2001, over 500,000 of these migrant workers were registered. Under this provision, registered workers became entitled to a minimum salary and access to health care and other basic labour protections.

In 2002, the RTG signed a memorandum of understanding on labour migration with the governments of Cambodia, Lao PDR and Myanmar. The memorandum established a framework for regular labour migration to Thailand.

In July 2004, a new open registration of migrant workers was launched by the Ministry of Interior to map out all categories of migrants in Thailand. Considered to be the first step in the implementation of the memorandum, it resulted in the registration of over 1.2 million migrants and their family members. For the first time ever, dependents of migrant workers were allowed to register.

The RTG, the United Nations (UN) and other international organizations, non-government organizations (NGOs) and other sectors of civil society are increasingly addressing the need for due protection of migrant workers and their dependents.

Over the years the registration programme has become very complex and demanding on the financial resources of migrants and employers. Presently, there is no policy that allows unregistered migrants to register; only those who registered in 2004 with the Ministry of Interior are allowed to obtain work permits from the Ministry of Labour. As a result, in 2005 and 2006 "re-registrations" were carried out in Thailand, which allowed labour migrants who had previously registered with the Ministry of Labour to renew their work permits.

A successful application for a work permit is contingent on the payment of required fees and the passing of a medical examination. For the purposes of this assessment, the most significant aspect of the registration process is that it allows migrant workers to register for health insurance and access health services through Thailand's "30 baht scheme". This means the migrants pay 30 baht per visit and receive medical attention no matter what the actual cost of the rendered service.[7] Workers who have irregular status, however, are not eligible for health care and treatment. In addition, even registered migrants who benefit from health services may face particular challenges in understanding and adhering to treatment regimens due to language barriers and movement patterns.

Linking Migrants and Health

Irregular migration involves conditions that increase vulnerability to illness and infection. This vulnerability stems from the social and economic conditions of source communities and can be amplified by the conditions faced by migrants during transit and at their destination. With regards to HIV, some of the factors that encourage high-risk behaviour and increased vulnerability among mobile populations are separation from family members, lack of a stable sexual partner, loneliness, cultural and linguistic isolation, a higher income and anonymity. According to the Center for Health Education and Research, "it is now more widely understood that individual behaviours and their health outcomes are strongly affected by their larger social, political and economic contexts in which these individuals live and work".[8] It is therefore clear that issues such as exploitation, lack of legal and social protections, and limited participation in the host community are linked to increased vulnerability to HIV, and generally, to ill health.[9]

The MOPH has identified HIV and other STIs as primary public health issues affecting the Thai border areas. Despite this, migrants often lack access to appropriate health services including targeted information, treatment of STIs, condoms, voluntary and confidential HIV/AIDS counselling, testing, treatment, care and support. Border area health systems face great challenges in integrating "migrant-friendly" and culturally appropriate HIV/AIDS/STI services into reproductive health, tuberculosis (TB) and other health programmes. In general, mobility, language, illiteracy and traditional customs all present significant barriers to HIV prevention efforts.

HIV/AIDS in Thailand and Myanmar

The HIV/AIDS pandemic continues to claim more and more lives despite prevention and educational programming in many parts of the world. In June 2006, UNAIDS estimated that 65 million people were infected with HIV and more than 35 million were unaware of their status. In 2005 there were 38.6 million people battling the disease, and an estimated 2.8 million who lost their lives.[10] This state of affairs causes significant issues for development, security and health care in the world today. It is important to recognize that while there are many programmes that increase awareness and advocacy to fight this pandemic among migrant workers, discrimination, denial and stigmatization of migrants cloud these efforts in many countries and communities.

Asia is currently home to about 60 per cent of the world's population and accounts for 19 per cent of men, women and children living with HIV/AIDS. This equals an estimated 8.3 million people infected with HIV/AIDS in 2005.[11] In Thailand the HIV/AIDS prevalence stands at 1.4 per cent (540,822 people)[12] and is concentrated among injecting drug users, men who have sex with men including male sex workers and transgenders, female sex workers, and clients of sex workers and their immediate sexual partners.[13] Although there are no concrete statistics on HIV/AIDS cases among migrant workers in Thailand, the 2005 UNAIDS report suggests that prevalence rates in the Thai-Myanmar border area are particularly high.[14]

HIV/AIDS Situation among Migrants from Myanmar in Mae Sot District, Tak Province

Located in the northern reaches of Thailand, Tak Province shares 560 km of its western border with Myanmar. The province has a population of 517,990 residents, with a one to one male to female ratio. In 2004 there were 120,658 migrants in Tak Province. Statistics indicate that only a small proportion of migrants have work permits; there were only 50,961 registered migrant workers in 2004.[15]

Tak Province consists of nine districts, five of which are located along the Myanmar border.[16] Mae Sot District is one of the border districts and boasts the largest population (migrant and Thai) in the province, with 116,733 people. According to the Tak Provincial Office, Mae Sot District had 84,270 registered and self-reporting migrant residents in 2004.[17] However, the non-Thai population in Mae Sot District is perhaps more than 119,000 people.[18]

In October 2004, the RTG decided to make Mae Sot District part of the Border Economic Zone Project.[19] This project attracted outside industry to the area and increased the demand for migrant workers. Low labour costs for undocumented migrant workers and tax benefit incentives from the government were additional factors that attracted business into the area. Most of the factories in Mae Sot District rely on migrants from Myanmar, with Thai workers in supervisory roles and foreign owners (most often from Hong Kong, Singapore or Taiwan Province of China) in managerial positions.[20] Because a very small number of workers have work permits in Mae Sot District, they lack access to proper health services and may be particularly vulnerable to HIV, exploitation and unsafe working conditions.

Commercial sex services in Mae Sot District tend to be located around construction sites and factories. These establishments employ mostly female migrant workers and tend to cater to Thai nationals. Male migrants from Myanmar usually solicit the services of migrant sex workers for their first sexual experience. The Prevention of HIV/AIDS Among Migrant Workers in Thailand Project (PHAMIT) asserts that “generally, if available, male migrant workers will seek out karaoke women or sex workers who are of the same language group in order to communicate more easily, but are also known to visit Thai sex workers”.[21] Financial constraints, undocumented status, and a new environment, culture and language create conditions of vulnerability, particularly to HIV, for sex workers and factory workers alike.

According to statistics from Mae Sot General Hospital, the most common health problems affecting migrants and their families are respiratory infections such as TB, upper respiratory tract infection, lower respiratory tract infection and respiratory throat infections. Environmental and sanitation factors also greatly affect migrants’ health in the area. In Mae Sot District in 2005, approximately 35,057 migrants received medical check-ups as part of the application process for a work permit. Individuals applying for a work permit must undergo a series of tests for leprosy, TB, elephantitis, syphilis, illicit drugs use, alcoholism and mental illness. These examinations determined that the most common illness affecting migrants was syphilis with 228 cases (0.65%), followed by mental illness with 61 cases, TB with 21 cases, elephantitis with 21 cases and lastly alcoholism with five cases. In the general population, including Thai and non-Thai nationals, morbidity data indicates that malaria is the most prominent disease affecting the District. However, the STI rate among sex workers could be much higher than the reported data since it is very less likely for them to undergo registration process.

According to the Tak Provincial Health Office, the sentinel HIV sero-surveillance indicated that in 2005 the HIV infection rate among migrant male workers was 7.3 per cent, and even higher for migrant female workers at 8.4 per cent.

Mae Sot General Hospital statistics indicate that 18 migrants in the area were HIV positive in 2003, increasing to 25 in 2004, and decreasing again in 2005 to 15 cases. These statistics, however, do not represent new positive cases but instead represent individuals who sought hospital treatment for opportunistic infections. In comparison, in 2003 there were 49 Thais who sought medical care and attention due to HIV/AIDS, decreasing to 30 in 2004, and increasing again to 36 in 2005. In Tak Province in 2006, there were 47 migrants and 45 Thai nationals who were AIDS patients and symptomatic HIV positive individuals.[22]

Due to barriers in accessing Thai health-care services, migrant populations may not be able to access proper medical services to test for STIs. This is especially problematic for women in child-bearing age, who may not be able to access information on contraception. This could result in unplanned pregnancies, possibly leading to self-induced, unsafe abortions.[23] In Mae Sot General Hospital, 128 abortions were performed for migrant women, compared to 133 for Thai women. In addition, post-STI

complications may lead to sterility, and in rare cases death. There are special STI clinics set up in Mae Sot by health workers who provide sexual health services to sex workers in the area. Consequently, statistics for STIs in Mae Sot District do not reflect the status of the general population, but rather indicate the sexual health status of sex workers in the area. In 2004, 7.34 per cent of non-Thai sex workers tested positive for at least one type of STI (71 out of 967). In 2005, the percentage of sex workers with STIs decreased to 3.82 per cent (46 out of 1,202). This significant decrease may be due to increased prevention efforts of NGOs and international non-governmental organizations (INGOs) in the area, as well as more active and culturally effective methods to disseminate sex and reproductive health information within the migrant community.

As a whole, the quality of treatment and services in Mae Sot District is relatively high. For treatment of illnesses, migrant workers have access to three primary service providers available within Mae Sot District – the government hospital, private clinics and the Mae Tao Clinic. The Mae Tao Clinic, led by Dr. Cynthia Muang, is dedicated to catering specifically to the health needs of the migrant community and is the primary destination for the sample population within this assessment. This may be due to the fact that the selection of health treatment facilities for the migrant community is greatly restricted based upon their legal status in Thailand.

There are many organizations and NGOs offering outreach services for migrants in the Mae Sot area. Those outreach services may include physical check-ups, immunization, health education, distribution of IEC materials for sexual and reproductive health, and general care and support. Some NGOs provide hospice services for symptomatic HIV-positive migrants.

Despite the efforts of many dedicated people in Tak Province, particularly in Mae Sot District, HIV continues to be a great problem in the area. The border between Myanmar and Thailand is very porous, opening its channels daily to new migrants. Many of these individuals arrive in Thailand for the first time, and some of them experience the additional stress of not having family and friends to support them during their journey or at their destination. There are many difficulties along the way, interwoven with complex circumstances that may lead to choices causing ill health. The stigma and discrimination associated with the disease also cause many to suffer in silence. This study aimed to learn more about how migration affects migrants' vulnerability to HIV, particularly among Myanmar sex workers and factory workers.

4. METHODOLOGY AND CONSTRAINTS

The assessment is a combination of qualitative (focus group discussions and individual in-depth interviews) and quantitative (survey) methods, enabling a more precise, deeper understanding of mobility and HIV vulnerability among the target migrant populations in Mae Sot District, Tak Province, Thailand.

Target Population

Strategic planning sessions among IOM's HIV/AIDS project officer, the Tak Provincial Health Office deputy chief, and two project consultants (one coordinator and one technical adviser) in Bangkok, along with a fact finding field visit with key stakeholders involved with migrant issues in Mae Sot District, determined the selection of the target population. Direct and indirect migrant sex workers and factory workers aged 15 to 49 were chosen due to the large numbers of migrant factory workers within and around the town of Mae Sot.

Sampling

Qualitative

The qualitative component of the sampling framework was based upon standard qualitative techniques. Both target populations were included within the qualitative research.

Sex workers were divided along type of work – direct versus indirect sex work– and took part in individual in-depth interviews and formal focus group discussions consisting of six to ten respondents. Three focus group discussions and four in-depth interviews took place for each type of sex worker.

For the focus groups of factory workers, they were grouped by sex and age (15 to 24 and 25 to 49 years of age), with the hope that these segmentations would lead to more open dialogue within the sessions. There were six focus groups of males, of which three were for under 25 and three for 25 years of age and over. Of the four groups of females, two were for under 25 and two for 25 and over.

Quantitative

Mapping of the target population was done prior to research, and as a result of the small number of sex workers (not more than 200 direct and indirect sex workers) and difficulty in access to them, especially the indirect sex workers, it was decided that implementing of a questionnaire with sex workers in Mae Sot would not merit statistical analysis and would be unrepresentative of the population. Since sex workers have been researched extensively with regards to HIV/AIDS in Thailand, it was assumed that qualitative methods coupled with a literature review would provide substantial data to understand the contextual vulnerabilities for this migrant population.

A total sample size of 819 factory workers was calculated using PPS method. The total number of major factories found in the catchments area had been mapped along with their total population size. Forty factories were found within the Mae Sot area. For selection purposes the cumulative population size was calculated and a sampling interval of 1,000 was used for selection. As a result, 18 factories were to be sampled with 40 respondents from each factory. Due to large factory population sizes the study was administered at a

total of 12 factories, six of which had a double sample taken due to their large size, with two factories refusing access.

As a result of the problem of access to the list of workers, random sampling was not possible. Once inside the factory, the team was instructed to attempt to take as random a sample as possible, though this was difficult because the team's movement within the factory was restricted at the request of factory management.

Study Tools

During December 2005 and January 2006, strategic planning meetings were held between the research team and the IOM HIV/AIDS project officer. These sessions produced the following outputs:

1) Focus group discussion and individual interview guide for factory workers and sex workers. Main topics include migration, socioeconomic background, employment, knowledge and attitudes towards HIV/AIDS and STIs, personal risk perception, sexual practices, discrimination and other adversities, condom knowledge and use, drugs and alcohol use, access to health services. Additional topics relating to the context of sex work and clients were contained within the guide for sex workers. The guide was created in English and translated into Myanmar by the lead qualitative researcher; and

2) Questionnaire for migrant factory workers. The questionnaire consists of eight sections, including general characteristics, knowledge and opinions of and attitudes towards HIV/AIDS, condom knowledge and use and sexual behaviour, knowledge of STIs, exposure to mass media and outreach interventions, access to health services, and HIV/AIDS stigma and discrimination. The questionnaire was created in English and translated into Thai.

Implementation

Qualitative

The lead qualitative researcher was Dr. Myint Myint Win, a Myanmar national. Dr. Win led all individual in-depth interviews and focus group discussions for sex workers and female factory workers. She assisted and took notes for the male factory worker component, which was led by a male Myanmar national residing in Mae Sot and working for an NGO. Subsequent to the data collection, Dr. Win transcribed and then translated all manuscripts into English.

Implementation of the qualitative component occurred in two phases, the first round taking place from 9 to 24 January 2006. The second round was undertaken from 9 to 13 February and aimed to gain additional knowledge and clarification of concepts from the first round. The discussion guide was pre-tested and adapted for such issues as language and cultural sensitivities.

All efforts were made to conduct focus group discussions and in-depth interviews in a neutral, comfortable and safe environment. Prior to each discussion, the group or individual was made aware of confidentiality, their right to refuse to answer any questions they deemed too sensitive and the need for their consent to proceed with the discussion or interview. A digital recorder was used in each session, though this was turned off at the request of the respondents if they did not feel comfortable. This occurred during a few of the sessions, at which time the interviewer made notes for future reference.

Access to indirect sex workers was a particular challenge. Local gatekeepers and NGOs, along with the staff of Mae Sot General Hospital who hold a weekly sexual health clinic, provided much needed assistance in creating focus groups. Upon completion of each focus group discussion, the facilitator would highlight individuals with whom to establish a link for future in-depth interviews or as the "seeds" for snowball sampling of sex workers to participate in this study.

Quantitative

In tandem with the second round of qualitative research, the questionnaire for male and female factory workers was implemented 11 to 28 February 2006.

As IOM and MOPH implement the Migrant Health Programme in Tak Province, eight migrant community health workers (five women and three men) were enlisted to serve as interviewers. All attended a training session to review, familiarize and ultimately pre-test the questionnaire.

Official letters from IOM had been sent to each of the selected factories requesting their assistance and cooperation. Access to the five factories located within the catchments area of Mae Sot General Hospital was granted with the assistance of a hospital official who accompanied the interviewers to the factory and met with management. Outside the municipality, nine factories had been selected, though two could not be accessed as district health officials were unavailable to assist with the liaison. The final sample consisted of 312 men and 507 women from 12 factories in Mae Sot District. The investigator facilitated and supervised all work.

The questionnaire was implemented in the evening hours during the week and throughout the day on weekends as per the availability of respondents and interviewers. Verbal consent by the factory managers and respondents was elicited prior to questionnaire implementation. (Consent was given verbally due to the literacy issue among migrants in Mae Sot District.)

Analysis

Qualitative analysis was conducted by coding key terms and concepts from the focus group discussion and individual interview guide. Coding was performed by the project

investigator with assistance from IOM. The research team discussed the day's findings each evening in the field. All analysis was completed by the project investigator.

Hard copies of the quantitative questionnaires were collected and brought back to the Institute for Population and Social Research (IPSR) at Mahidol University, where the data was entered, cleaned and analyzed using the Statistical Package for Social Science (SPSS). The technical adviser was charged with conducting the quantitative analysis and employing data entry personnel from the university.

Constraints

A number of constraints surfaced as the fieldwork progressed. Though they were difficult in nature and had an influence on aspects of the methodology laid out in the sampling framework, none of the constraints led to any major methodological failures.

Access to the factory populations was the primary constraint due to past negative experience of factory management in working with NGOs. Much work had to be done to gain management confidence and understanding. This included providing copies of the questionnaire for review prior to implementation, producing a letter of intent from IOM with the signature of the health authorities, and frequent contact to request permission, organize logistics, answer questions and ease concerns. Though all efforts were made to accommodate the needs of management and dissuade them from any notion of malicious intent, two factories within the sample refused to provide access to the team. As a result, and to meet the target sample size of 800, the number of sampled respondents within each factory had to be increased.

Factory work experiences annual fluctuations, with the low season occurring from December through March, which was when the research was undertaken. Some of the randomly selected factories that had an insufficient population size were thus replaced with the next factory of similar size on the master list. The majority of the factory workers live in dormitories on the factory premises, and all factories placed restrictions on their employees leaving the premises to take part in the research. As a result, data was gathered under conditions that did not always offer a neutral and private environment. As they conducted the questionnaire, the team was monitored or shadowed by the management in certain factories. Every effort was made to keep the selection of respondents in the factory as random as possible, though some amount of selection bias may have occurred. Some managers restricted the amount of time that the team could spend on factory grounds. One factory allowed the team just one hour on the premises, and only a fraction of the 80 sample respondents could be interviewed. A return visit was denied. Although the planned number of interviews was undertaken, some changes had to be made to the sampling framework due to problems accessing some factories.

The research team decided not to utilize self-administered survey questionnaires because a proportion of the target population was illiterate. While this ameliorates selection bias against including illiterate populations from the sample, it also introduces the possibility that respondents would not answer sensitive questions as directly. Another possible bias

could result from the multiple languages involved in the process. The questionnaire was developed in English, translated into Thai and then conducted in Myanmar by the field team. All members of the team can read Thai and can speak Thai, Myanmar, and/or Kayin fluently, but because they grew up and attended school in Thailand, some are unable to read their native Myanmar language. Careful training was provided to ensure that the questionnaire was understood by all and administered consistently. Due to the length of time to conduct the assessment and the availability of field staff, this bias was deemed acceptable by the principal investigators.

5. FINDINGS

For simplicity, sex workers and factory workers are addressed separately within the findings. As the qualitative discussion guide and quantitative questionnaire complement each other, the two research components are presented together for each target group under the four main areas of migration, employment, behaviour and health.

Narratives from the qualitative transcripts are included in the body of the text to bring forth the voice of respondents.

Sex Workers

Based upon qualitative analysis, the mean age of sex worker respondents was 22 years. All had received formal education, with a mean completion of fifth standard, though the variation of educational standard (i.e., level or grade) was large, with a range from second standard to tenth standard.

Migration

Reasons for Migration

The respondents originated from a variety of locations within Myanmar, though predominantly from the central (Bago, Yangon) and eastern (Hpa-An, Mawlamyaing) regions.

The overwhelming reason for the respondents' migration to Thailand was financial burdens back home. These burdens arose from family difficulties (debt, sickness and death), lack of family providers among siblings, and extremely low pay for work in Myanmar. One 22-year-old direct sex worker from Myanmar described her situation in Myanmar as follows: *"In Myanmar we can't get 1000 kyats* [about 40 baht a day], *even working hard. A cement worker gets only 500 kyats a day. That 500 is not enough to buy curry for a family."*

All of the women highlighted their need to provide for dependents, such as children, parents, husband and extended family members living with them in Thailand or residing

back home in Myanmar. Several of the women had been married and divorced, and a few several times.

One indirect sex worker stated: *"My husband is in jail. I have come to work here with my child and my mom. Now I have a total of 11 people at my house – my sister, her husband and her children. They work in the factory but don't have money. They don't work and I have to feed them. I have to pay for the room rental fee, like last month, it was 1,816 baht. I can't save money. I don't want to work anymore like this."*

Methods and Modes of Transportation to Thailand

A range of companions and contacts facilitate the migrant's journey to Thailand. Many cross the border with relative ease together with a family member or friends who had been to the Thai side previously. More vulnerable to exploitation, some young women begin the journey to Thailand alone, and meet someone in Myawaddy who offers to bring them to Thailand for a fee.

Brokers are present on both sides of the border and seek to make money through providing transport and employment assistance to migrants in need. In the context of sex work, some brokers inform the women about the specific type of work prior to providing assistance while others merely explain that the women could make a substantial amount of money sitting and talking with customers at a bar.

One young woman who travelled to Mae Sot with a broker said:

> *"Because it's all mountains I was very afraid. Then we crossed the bridge and arrived here. They showed us to the "houses"* [term for brothel] *and people from one house took us. Other women had been left in a house in Myawaddy. I didn't know what a house was, or what kind of work was involved. So I waited. They* [broker and brothel, bar or restaurant owner] *phoned each other two hours after our arrival. Then they came with the cars. Only then were we told that we had to work in restaurants, but we couldn't refuse the work then because we were ordered to pay back the money to the woman who brought us here. This house gave her* [broker] *1,000 baht for sending us here. Then she got 1,000 for the expenses on the way. So, it was 2,000 for each of us. We have to pay back this 2,000. We were taken to that place because we didn't have money. So then I had to do it as there's no choice."*

Another young woman had a similar story and described it as follows:

> *"The first time I came with a broker because my parents had financial difficulties. So I decided to work and asked a broker to bring me here. At first I dared not do such work and I asked why this kind of job. But the broker said that it was the same as having a husband and it was like marrying someone, just a while. Then she said that if I got enough money I could go back* [home] *by myself. I was 15 years old then."*

Not all brokers work in conjunction with the brothels and karaoke bars in Mae Sot. Some facilitate contact with factories and farms and are paid directly by the migrant. This topic is discussed further in the factory worker segment of this report.

Primary modes of transportation available to the Myanmar population are buses, pick-up trucks, express cars, “cars without windows” and boats crossing the Moei River heading to the small entry gates throughout Tak Province or to the main bridge in Myawaddy. Boat crossings, unlike crossings at the gates along the road or the main bridge in Mae Sot, have a reduced Thai military presence and allow traders to transport their goods to and from their home in Myanmar. Boats are a popular form of transportation to Thailand.

In the past, footpaths through forested regions were a common route into Thailand. As public transportation and the infrastructure have improved in Myanmar, nearly all respondents currently migrate to Thailand using vehicular means.

The existence of gates and checkpoints found along the major routes on the Myanmar side of the border is a constant adversity. The distance travelled and number of states and divisions needing to be crossed dictate the number of gates one encounters. Upon arrival at a gate the security personnel request passengers to disembark and provide personal identification. Without proper documentation, such as a national identification card, the security personnel can refuse passage or detain individuals. Several of the respondents noted a level of discrimination by the security officials towards young adults travelling towards the Thai border.

Pattern of Migration between Thailand and Myanmar

A pattern exists in the frequency with which the migrant community residing in Thailand returns to visit dependents, family and friends. Monthly or, to a lesser extent, weekly trips to purchase goods from Myawaddy are common. Migrant sex workers seem to return home once they are financially stable or in order to marry.

The narratives of the sex workers often described the following environment:

Upon arrival in Thailand, the women begin to work in the sex profession. (The reason behind working in the profession – pay and savings – is discussed further in the following section.) They usually work for an initial four to eight months. In most instances this allows them to save a substantial amount of revenue, which they in turn use to invest in a business or other endeavour in Myanmar. After paying off any debt owed to the brothel or karaoke boss, several of the respondents returned to Myanmar, be it where their dependents reside or simply to Myawaddy, and began a small business, such as a teashop, or provide for the family to continue working as farmers. Many had returned for periods of a year or more with little intention of returning to Thailand.

All the sex workers that took part in the discussions said they wanted to stop working in the profession and were actively building their savings for the future. One 24-year-old

sex worker said: *"I have to work here like I am a businesswoman. It's good to work for one, two months or at the most four to five months. I work till I get some things for my kids, like a house, then I have the capital to invest."*

After returning home and new difficulties have arisen, many young women return to their old life in Mae Sot, a life that provided them with enough money for their dependents and their future. This story of migration was described very often during the discussions and interviews. Some respondents said they returned to Mae Sot as many as three or four times.

Employment

Rationale and Entry into Occupation

Whether the women followed a broker or went on their own to Thailand to work in the sex industry, the commonality in all these migrants' narratives was the lure of the amount of money that can be made over a relatively short period of time in comparison to any of the other migrant professions available in the Mae Sot area.

Few of the respondents came to Thailand seeking to enter the sex industry. The women noted that the most desirable work was in a factory, though due to the lack of available positions, the skills required to work in certain factories, and the presence of a high and low season, there was not a great chance of employment. On arrival, migrants may have to wait several months for a position or to meet a gatekeeper to facilitate access to a factory. In the interim, respondents said they sought employment in the agricultural sector or as a domestic housekeeper. Due to financial difficulties, adversities (such as discrimination, difficulty of work, lack of or little pay per day) and no available factory work, the women began to seek new and more profitable employment.

If not through the services of a broker, the women's entry into the sex industry was mainly through contacts in Myawaddy or Mae Sot. After arriving, many respondents said they started making new acquaintances and discussing their life, desires and difficulties. The respondents said that these acquaintances (such as past or present sex workers, motorcycle taxi drivers, etc.) introduced them to the sex profession. In most instances the women began working reluctantly, though as their initial fear passed, their ability to begin providing for themselves, their family and their future instilled a sense of ease in an otherwise difficult context. One direct sex worker said: "I was very afraid because I haven't done work like this before. Then I went with the Thais. Then I had to receive the customers."

Many respondents openly admitted that their job was not ideal and that it came with several taboos. One indirect sex worker discussed how tired she was of getting made up every night to talk and sleep with clients. They also said, however, that working in the sex industry provided them with a level of freedom and capital that could not be attained through more conventional means.

Permits

Very few of the respondents said they had a work permit, though some said they had a stay permit. The yearly fee for a permit is approximately 3,800 baht, which is arranged for and paid by the employer. Migrants are then bound to their employer until their permit debt has been paid off. They have little leverage in any matter of negotiation. Though the permit provides them with the right to work in Thailand, their profession negates that legality and they remain constantly vulnerable to prosecution by security officials. One indirect sex worker said: *"Yes, the bosses* [brothel owners] *spend money for their* [the sex workers'] *permit, so if they change from boss to boss, they [the boss] can create problems for the girls."*

Pay Rate

The price paid by the client is dictated by whether the sex worker is newly arrived, a direct or indirect sex worker, and paid by the hour or night.

For direct brothel-based sex workers, a woman is given the term "*newcomer*" if she has been at the establishment less than one year. She is more in demand and her hourly rate is higher than that of someone who has been there longer. An interesting phenomenon that occurs within the sex worker community is the yearly migration of women back to Myanmar once their yearly "*newcomer*" period has expired. With the savings they have acquired over the year they return home, visit family and friends for an extended period of time, and then return to Mae Sot to be reintroduced as a "*newcomer*".

Direct sex workers are paid hourly or for the whole night, though the majority of respondents stated that 30 minutes was the average length of time spent with hourly clients. The hourly rate of the "*newcomer*" is 500 baht, which is split between the house and the employee. If the woman is taken out of the brothel to a private hotel she receives an additional 50 baht. Daily wages for direct sex workers are by no means constant and fluctuations occur throughout the year. High-end estimates of daily pay are between 800 to 1,000 baht, while at other times the women may take home 200 to 500 baht per day.

Indirect sex workers are found mainly in the karaoke establishments of Mae Sot. They are at the customer's disposal for conversation and companionship while at the karaoke bar. The women receive 80 baht for each hour the customer remains in the establishment and 20 baht for every drink served. For sexual services the fee is 1,500 baht, of which the house receives half. If the client exceeds the hourly limit another 500 baht must be paid, and the nightly rate is an additional 1,000 baht added to the original 1,500. Some of the respondents noted that tipping was not customary, though they did receive tips every now and again.

One respondent working in a brothel discussed unforeseen expenses, noting two in particular. All the women staying at the brothel must pay a 700 baht monthly housing fee. These fees are automatically deducted from their salaries. Every brothel and karaoke bar

has its own policies and fees, thus the above is mentioned only to provide some insight into the additional costs encountered.

Monthly or bimonthly savings are collected and either put into a bank account in Myawaddy or given to a carrier who administers a fee of 6 to 10 per cent of the total amount. The savings are brought back to the family and dependents in Myanmar.

One direct sex worker said that if they were careful they could save 300,000 kyat [about 10,000 baht] each month.

Clients, Sweethearts (Boyfriends or Lovers) and Number of Partners

Clients are diverse in age, sexual experience and ethnicity and include Thais, Chinese, Indian and Myanmar clients, aged from late twenties to sixties. The ratio of Thai to Myanmar is approximately two to one. It has been documented that migrant men often elicit the services of sex workers for their first sexual experience, though the bulk of clients are traders from Thailand and Myanmar, factory owners, businessmen, police officers and military.

In conjunction with working as a sex worker there are those who have a sweetheart. Brothel-based women are restricted from leaving the brothel, due to either fear of police detection or the limited amount of free time during the day. Those with a sweetheart are usually indirect sex workers. Their clients can become their regular partner, that is, their lover or boyfriend, in time. One indirect sex worker said: *"They have someone who came once, twice, then came frequently and fell in love with them."*

Many sex workers expressed a dislike for clients who used drugs and were drunk. One indirect sex worker said: *"I also choose the customer. Some don't look nice, don't have a clean personality and I am also afraid. I am afraid that they don't use a foil for this money."*

Safety is an issue that is stressed by the majority of brothel and karaoke managers. Employers often remind the women who are taken out of the brothel or karaoke bar to be prudent and to keep alert for anything out of the ordinary. At any time the women may refuse to provide their services and the money is reimbursed to the client. This, however, is highly dependent upon the opinion and attitude of the management.

The most obvious difference between the indirect and direct sex worker is the price and number of partners per day. Indirect workers may have one or two clients a day, including in the evening hours, and it is not uncommon for them to go several days without a client paying for sex. On the other hand, direct sex workers have on average three to four hourly clients per day and one full-night client.

Many respondents noted that their Thai and Chinese clients had sexual intercourse with them once during the hour, whereas in many instances the Myanmar clients used the full hour to have intercourse with them twice.

Behaviour

Sexual Practices and Situations

Though a sensitive topic that seemed to elicit embarrassment, the issues of oral and anal sex, forced sex and other precarious situations were discussed within the focus group discussions and in greater detail during the in-depth interviews.

Due to the nature of the work and the ability of the client to take a sex worker out of the brothel or bar, the women are vulnerable to violence and lack power to negotiate sexual terms and condom use. The following narrative, though graphic and perhaps not representative of all situations, is nonetheless an example of the dangers facing sex workers.

> *"I have had many experiences and I was afraid one time. They told me there was only one* [client] *and other men came upon me. A lot of them. After that, I had to go to the clinic. It was about one year ago. At first I was ashamed and thought about whether I should tell the staff the truth or not, but later I told them about it. It should be told to them, right?"*
>
> *"The doctor from the hospital asked what happened. They said that the womb was swollen, there was bleeding from the opening too. So I told them. There were 12* [men] *in total, but I could stand only nine of them. They pointed a knife at my throat. The staff stuck a plaster on that place. Then I stayed in the hospital for three or four days. The lady boss came to see me. She said that she didn't think it could happen like this, he* [the client] *was from Myanmar like me. He paid the fee for the night stay, it is 1,500 baht, so I thought I should go, so I went with him. I went because I saw that he was young. He went to the restaurant and had beer with his friends. Then I saw them talking to each other. I did not understand Thai much, so I didn't know what they were talking about. Then he took me through a small path and then far away. Then we arrived at that place. There were no coverings. The house was in a field. I asked him what he was going to do with me and why he took me there. He told me to wait a while and his friends would come. So I waited and waited. Then when they came there were about 20* [men]. *They came with scooters and followed us. But some left so only about 12 came upon me at the same time. Some pulled my legs and some touched my breast. One who was only about ten years old touched my breast. Then I thought that I was a mother so I let them do it. They also pointed a knife at my throat and it bled. I had to let them do it. Then they left me one by one, so quickly that I had to call them to come back to take me home. When I shouted at them they ran away. They were afraid of me. It seems that they hadn't had an experience* [like that before]. *The hands holding that knife against my throat had been trembling. Then I had to walk back. At that time I was bleeding from the womb* [vagina] *and had pain in my belly. I was hospitalized as soon as I arrived back.*"

> *"They took money from me. At that time, I had money with me, about 750 baht. They took 500 baht to buy themselves beer. I had to shout at them to leave some money for my return home. It's lucky that they left over 200 baht for me. It seemed that I had to pray for them, pray that they may be healthy, that I was not dead. Because I have heard of such group sex. One of our friends was killed because she wore a gold necklace. They did to* [raped] *her and then killed her by cutting her throat. My lady boss always reminded us not to take all the gold and not much money with us when we went out with the customers. So, I didn't bring anything if I went out. But on that day, I thought that I had to go out so I went with short tight pants and a blouse without sleeves, I prepared "hot short"* [dressed revealingly] *and went out. But who knows, there were about 20 who followed then."*

All respondents stated that they did not take part in or enjoy oral or anal sex with clients, but that being propositioned was not out of the ordinary. During the in-depth interviews, some respondents discussed being grabbed by the hair, having their arms forcibly folded behind their back and told to perform oral sex. In several of the transcripts, mostly in the in-depth interviews, the girls spoke of having been forced to perform sexual acts they would normally refuse. One direct sex worker said: *"He folded my arms and didn't use the foil."*

Another direct sex worker described one of her experiences:

> *"I went with customers and they were bad, very bad. They came to the house and took me. We couldn't refuse and had to follow. When we were inside, he asked me to do it, his thing* [penis]. *I refused but he asked me to do his thing with my mouth. I said that I couldn't. Then he brought out his gun and put it on the pillow, and I was very afraid. I was very afraid then. I didn't know what I should do, so I cried, but it didn't work so I ran out with a sarong on my body."*

"Opening the Package"

The term "*opening the package*" is perhaps an interesting finding from the qualitative component of the sex worker study. It is a metaphor used for clients who purchase or acquire the services of a virgin.

Some young Myanmar women are brought to Mae Sot by friends, family members or brokers for their first sexual experience. The women often have no motivation to stay in Thailand, and migrate merely for this purpose. On the following day they travel back to their home in Myanmar with their earnings. Some women do, however, begin to work in a brothel or karaoke bar and the money is sent to their dependents by a carrier or through a bank in Myawaddy.

The women receive between 15,000 and 20,000 baht for the initial "*opening*", with certain brothels or employers receiving a percentage. It is customary when purchasing the "*opening of the package*" that the woman is provided a few days to rest, then the client

who purchased the first service is granted her second sexual experience. For this she receives another 5,000 baht, which she must split with the employer.

The women are merely asked if they are virgins, no physical examination is administered. If the woman is discovered not to be a virgin the house must pay the client twice the negotiated initial fee of the service.

Condom Use

Condom use is variable and dependent upon the attitude of the user and her partner, the employer's policy and the woman's education. The desire to use condoms was certainly expressed during the interviews. Through peers within the same profession or clinic or NGO trainings, the sex workers are shown how to use condoms properly and explained the reasons for their use. Though this knowledge is provided, a gap remains between having proper knowledge and employing prevention behaviour. Most sex workers did not know how to use a condom prior to working in this profession in Thailand.

Clients most likely to use condoms are Thais and Chinese, and it was not uncommon for them to use two condoms at a time. One indirect sex worker said: *"The customers are afraid of me* [laughs]. *The customers are also big so they are afraid. I told them that the doctor said we should use only a single layer but some haven't learned about this. I just let them use it if they wish* [laughs]." An direct sex worker said: "*We put it* [condom] *on. They put on only one but we put on another one. When they are very strong the foil breaks and it's risky for us to get infections."*

Clients from Myanmar, especially those of the Kayin ethnicity, are less inclined to use condoms according to the sex workers, perhaps due to lack of knowledge.

Condoms are rarely used with regular non-commercial partners such as boyfriends and husbands. When they are used, it is mostly for contraceptive reasons. In the context of *"opening the package"* as discussed above, condoms are not used.

Of significant concern are situations involving the injection of the penis with oil or other fluids for enlargement. Sex workers commented that due to the size of the penis, condoms could not be used and they were at a greater risk of vaginal abrasion, which heightens the risk of HIV transmission. The use of lubrication was mentioned, though its availability and the knowledge of its use are low.

The respondents said that negotiating condom use was quite difficult when there was a lack of common language and when drugs and alcohol were used by clients. Some clients attempt to remove the condom during intercourse. The respondents mentioned that there were situations when clients had paid an extra 100 baht not to use a condom. Reasons given to the sex workers by their clients for not using a condom were that the condoms were too hot and resulted in loss of sensation and the clients wanted to feel skin on skin.

Questionnaire results show that condom breakage was not a common occurrence though it happened occasionally, especially during rough sex. Some sex workers said that they could feel or even hear the condom break, in which case they said they replaced the condom.

During weekly clinical visits to Mae Sot General Hospital, the set protocol of the clinic staff is to ask the sex workers how many condoms were broken during the previous week. Because these workers do not want to tell the clinic staff that they were not using condoms, the response to this question is actually the number of times that condoms were not used. A direct sex worker said: "We are ashamed to tell them that we don't use them. And on the other hand, they asked us to use them. So if we say we don't use them, it will be like we don't listen to them." Because of this breakdown in trust or communication, the occurrence of breakage is grossly over-reported and non-use of condoms under-reported.

With regards to preventing HIV/AIDS/STIs and promoting knowledge of these diseases, it is advantageous if the boss or employer is in the habit of promoting condom use and asking the women to protect themselves. An indirect sex worker explained: "The boss tells us to use them [condoms] too. And we have to go to the hospital every week, and the staff gives one box of condoms. We have to give it back to our lady boss when we arrive back. We use them when we are going to sleep with customers."

Condoms are available free of charge to sex workers who attend the weekly clinic at Mae Sot General Hospital. Every woman who attends the clinic is given one box containing 50 condoms. All sex workers, both direct and indirect, have access to condoms through their place of employment free of charge and are encouraged by most of the management to use them with all their clients. On average, two or three condoms are brought to the room with each client in case of breakage or the desire of the client to have multiple sessions during the allotted hour.

Drugs and Alcohol

Few of the respondents admitted to drinking alcohol or using any kind of illicit drug, though there is indication that both clients and sex workers indulge in drugs and alcohol. Clients who use drugs also ask the women to take methamphetamines prior to sexual intercourse. Very few women admitted to taking the drugs.

By far the most popular drug is the methamphetamine called by Thais "*yaa-baa*." This drug comes in a variety of colours, with pink, green and brown being the most common. They are administered through either mixing with water or inhaling the fumes by burning the drug using the foil of a cigarette package. In the second case, the foil is formed into a small bowl, and the drug is crushed and placed inside the bowl. Using a match or lighter the foil is heated from below and in turn the "*yaa-baa*" begins to burn and the smoke is inhaled.

Many sex workers admitted to being worried of taking on clients they knew to be under the influence of either drugs or alcohol, saying they sometimes became overly aggressive and rough. As an effect of the "*yaa-baa*," the clients' erection lasts for a significant amount of time and they seem to tire very slowly. One direct sex worker said: *"They don't need to sleep – they can go the whole night."*

Much like their clients who use "*yaa-baa*," sex workers who take the drug said that the most significant positive effect was their ability to have many clients in a night due to the increased vigour and energy the drug supplies. As a result they can make a significant amount of money.

An indirect sex worker described her experience with the drug:

> *"I think I lose weight and I can work better. I would be active the whole night and could withstand even four or five customers a night. If not, I couldn't endure it. If I don't take it* [the drug] *for a while, I feel like I become heavy and don't want to work. For my young husband who left me, his organ was erect all the time when he took that drug, and he could do it several times a day. And for women, we can withstand them a long time, if not, how can we endure it* [laughs]. *Some said that if we use horse drugs* [another term for methamphetamines] *the voice becomes better."*

Many sex workers said adversities include the constant issue of negotiation with clients that respondents described as *"bad men"* – those under the influence of drugs and/or alcohol and expect unprotected sex. Another adversity they said they faced was their inability to communicate well in the Thai language.

Health

Health Services

Each Monday a reproductive health clinic for sex workers is offered by Mae Sot General Hospital. The clinic provides sexual health IEC coupled with HIV/STI testing and treatment. One direct sex worker said: *"The staff from the hospital show us pictures, like the ulcers on the man's organ and some have discharge, like this. Then I know the one without any cure."*

The outreach programme at Mae Sot General Hospital is supported by the IOM-MOPH Migrant Health Programme and employs IOM-MOPH migrant community health workers to act as liaisons. As part of the routine services, the sex workers receive an HIV test yearly.

Through this partnership among the health authorities, NGOs and community-based organizations and brothel owners, virtually all brothel-based sex workers attend the clinic. Sex workers new to the profession are encouraged and required by brothel management to undergo an initial check-up at the clinic. In instances where the sex

worker refuses to attend, employers are known to withhold a percentage of the sex worker's income.

Few indirect sex workers attend the weekly clinic. If they are not attached to a brothel or bar where the employer promotes positive personal hygiene and health, there is no policy or outreach in place to target these women. It is under their own volition and desire to attend the clinical services and take an active role in their sexual health.

Sexual health training by NGOs has been a positive force in Mae Sot District, though the trainings take place sporadically. Sex workers have been brought to NGO trainings and instructed in HIV/STI prevention and transmission through multimedia, pictorials and adult learning theory presentations.

With the proper documentation (a registration record with the police and a health check-up certificate, which are also the documents required to apply for a work permit) migrants can acquire the health insurance card, enabling them to receive health services from Mae Sot General Hospital and associated health centres through Thai social security or the "*30 baht scheme*". Though this policy was set in place by the RTG it excludes those who are not in possession of proper documentation, which is a large proportion of the migrant population residing in the area. Most of the migrant community are very aware of the Mae Tao Clinic or the "*students' clinic*", as it is commonly referred to in the Myanmar language. The Mae Tao Clinic offers a relaxed and comfortable environment for the migrant community, where sex workers can openly discuss their problems, symptoms and fears with the medical staff, as they speak a common language. That being said, for issues relating to testing for STIs and HIV, sex workers prefer attending the hospital clinic due to its anonymity. One indirect sex worker explained: *"Usually they go to the students' clinic. We can speak in our language. But there are many people from Myanmar, so some girls feel ashamed to go there because it would be revealed that they do this kind of work. In the hospital, they have a separate place for the girls, so we feel safe to go there."*

Though the sex workers have a sense of anonymity in the hospital among their peers, many remarked that confidentiality was another issue. One direct sex worker said:

> *"They didn't want to go to the hospital before because the staff asked loudly about their bodies and their customers. But the attitude is better now because someone told the staff to treat them* [sex workers] *well. But sometimes in front of others the staff tell the girls to take injections, so they* [others in the clinic] *know who had become kyo de or broken due to an STI, and they whisper to each other about it."*

Knowledge and Attitudes towards HIV/AIDS and STIs

Sex workers within the qualitative sample have a basic level of knowledge and a positive attitude towards HIV/AIDS and STIs, though this is dependent upon their length of time

in Thailand and their exposure to and the availability of sexual health services and related IEC materials.

Prior to arriving in Thailand, several sex workers admitted that although they may have heard the terms HIV or AIDS, they had no knowledge concerning symptoms, transmission or prevention, and no prior knowledge of STIs before their initial visit to health services in Thailand. One direct sex worker stated: *"We are afraid of diseases – AIDS – but don't know about other infections, don't know the others apart from AIDS. I know the different stages of AIDS because I have attended some training the* [government] *staff gave."*

Though their knowledge is at a basic level, the women expressed a healthy sense of personal risk and commitment to protecting themselves through the use of this new knowledge, which is provided to them by outreach, trainings, lectures during regular STI check-ups, and other interventions.

Factory Workers

Factory workers represent the major proportion of the migrant community residing in Mae Sot District. The porous nature of the Thai-Myanmar border, the financial opportunities of working in a factory and the lack of employment opportunities back home all fuel this flow of human resources and capital to Mae Sot District.

Due to the size of the migrant factory worker community and the little that is known about their migration stories, adversities and vulnerability to HIV, both qualitative and quantitative methods were employed for the male and female respondents.

General Characteristics and Migrant Demographics

Over 85 per cent of respondents are of the Burman ethnic group, with 5 per cent Karen and 4 per cent Mon. Over half of the respondents fall between 20 and 30 years of age, with a mean age of 25 for males and 26 for females. The mean length of time spent living and working in Thailand is quite high, with males residing for 4 years and females a similar duration at 3.8 years. At 95 per cent, Buddhism is the predominant religion of the respondents, with Christianity and Islam representing a small minority of the sampled population.

Factory workers in Mae Sot District come from a variety of locations throughout Myanmar. Based upon questionnaire results the pattern of migration is relatively the same for both genders and displayed in Table 2.

Table 2. Respondents' Place of Origin in Myanmar

Origin in Myanmar	Male		Female	
	Percentage	Number	Percentage	Number
Mawlamyaing, Mon State	20.2	63	26.4	134
Bago, Bago Division	20.2	63	28.4	144
Yangon,Yangon Division	11.2	35	14.4	73
Hpa-An, Kayin State	7.4	23	3.2	16

Others	41.0	128	27.6	140
Total	**100**	**312**	**100**	**507**

In several of the focus group discussions, respondents confirmed that a large number of migrants came from the four particular areas listed above, while others discussed their lengthy overland journeys from more distant states and divisions, such as Pakkokhu in Magway Division, Sagaing in Sagaing Division, Sittwe in Rakhine State and Hakha in Chin State.

Perhaps due to the young age at which migrants decide to move to Thailand and the traditional values placed upon marriage, the majority of the respondents are single, as Table 3 demonstrates. For those who married, either prior to migrating to Thailand or after they have arrived and met someone, the mean age at marriage for both sexes is approximately 22 years.

The majority of migrant workers in the sample stated that they were unable to speak any Thai (88% for females and 79% for males). This could be in part due to the large number of people from Myanmar living and working in Mae Sot District.

Table 3. Marital Status of Factory Workers in Mae Sot District

Marital Status	Male		Female	
	Percentage	Number	Percentage	Number
Single	58.0	181	65.1	330
Married and lives with spouse	34.3	107	23.7	120
Married but does not live with spouse	6.4	20	5.3	27
Not married and lives with partner	0.6	2	0.4	2
Divorced, separated	0.6	2	3.7	19
Widowed	0.0	0	1.8	9
Total	**100**	**312**	**100**	**507**

Migration

Reasons for Migration

The vast majority of migrants that work in factories in Thailand come from the agricultural and rural areas of Myanmar's states and divisions. As financial and other difficulties arise, families are forced to explore new options that can aid in providing for the extended family. One male factory worker said: *"Actually my uncle got a plot of land to prepare a coffee plantation. But later they occupied it to broaden the road. That's why we don't have it. And in the next years, the farm was not productive, so we came here. And we have a big family, eight siblings, and here we have four."*

When questioned about the reasons behind their migration to Thailand, 53 per cent of females and 61 per cent of males stated that an inadequate income and financial difficulties in Myanmar facilitated their choice to migrate. Limited job opportunities in their community in Myanmar were also widely reported by 35 per cent of female respondents and 29 per cent of male respondents. It was not possible to continue working

as farmers or in trade, and they heard through relatives, friends and other acquaintances about the opportunities that could be found in Mae Sot District.

To provide context for the situation of many migrants a personal account from a female factory worker, which represents the vast array of personal migration stories of migrants in Mae Sot District, is quoted below.

> *"I am 38 years old now. My sisters-in-law used to send money back [from Thailand] frequently. I worked as a tailor at that time in the lowland* [part of Myanmar]. *I was busy day and night. From here* [Thailand], *my sisters-in-law sent money one month and things another month and I liked them. Then my sisters-in-law told me that I should come here and work in the sewing section* [of the factory]. *So I left my business and let my husband take care of my kid, who is only one year and four months old. My husband didn't like me to come here and work because he said he could earn for me and I just needed to work at home, but I was greedy. I came here and first worked in the sewing section. As I was getting used to the manual machine I had to use the motored machine, so I had to start from the beginning. I didn't want to do this and later joined the garment factory. Then I was able to save money and send it back home. I've been here for a long time and eat and drink in this side's* [Thai] *manner, and I feel like I have become happy here. I was not suitable to stay in the lowland because the local authorities would come and ask for a lot of tax and I don't like this. My mother-in-law said to me that if we just object like you, we might be in jail one day* [laughs]. *In our part, the families have to earn for ourselves and let alone getting help from the government. And in such a condition, they asked us to fence our houses, then paint the houses and so many things. Then after painting, they said it wasn't this design, to repaint again so we had to do it again. So when they asked for so many things, I had to talk with them frequently and sometimes I was not happy to stay there. For here, I just need to pay the debt and save money and just send it back. I don't need to worry about increased prices of goods here.*

Companions, Modes and Methods of Transportation

The data in Table 4 shows that respondents tended to travel with a companion on their initial journey to Thailand. Siblings and friends represent the highest percentage of companions, though 25 per cent of males and 20 per cent of females said that they attempted the journey on their own. Few came with brokers.

Table 4. Individual Accompanying Respondent During Initial Migration to Thailand (multiple answers possible)

Companion	Male		Female	
	Percentage	Number	Percentage	Number
Friends	29.5	91	22.7	116
Alone	25.0	77	20.1	102
Siblings	21.2	66	25.4	129
Relatives	11.2	35	14.8	75
Spouse	7.7	23	9.3	47
Parents	6.7	20	8.1	41
Agents	2.9	9	5.5	28
Children	0.0	0	0.8	4

Over recent decades, migration within Myanmar and to Thailand has been transformed due to insurgent activity, military action, development of infrastructure and governmental policies towards the flow of goods, services and people between the two countries. Within the last decade the opening and improvement of roadways has meant greatly improved public and private transportation, including trucks, buses, trains and cars that are readily available and well known throughout Myanmar.

Depending upon the origin of their journey, migrants may take one or all of the methods of transportation available to them. One female factory worker described her journey:

> *"I am from Pyinmana* [in southern Mandalay Division]. *I took the train to Bago and from there to Yangon. At that time as I didn't have a contact I just stayed with my friend. From Yangon I didn't know the way so we went to Bago and then to Mawlamyaing and then to Thamanya. From Thamanya I came with the DKBA* [Democratic Karen Buddhist Army] *and with a car, and they settled the problems. We didn't need to do anything. We arrived at Myawaddy and then here."*

As the female factory worker mentioned, the DKBA cars provide a somewhat different service. Only found in Kayin State,[25] the service is slightly more expensive than other forms of public transportation. The DKBA service is attractive and set apart from the others due to its ability to allow passengers to pass through checkpoints and gates without disembarking from the vehicle. Prior to departure the conductor collects the fee and all identification, and arriving at the gate, takes care of all legal matters. Therefore, those who are young or do not have identification have a much better chance at succeeding in their migration attempts. The majority of respondents highlighted that the DKBA provided a sense of ease during the often stressful migration.

Beyond the adversities they faced on a daily basis back home in Myanmar, the predominant adversity during the migrants' journey is the discrimination faced at the various checkpoints throughout Myanmar. This is particularly the case for those who are young or who migrate without an identification card.

> *"I went to Mawlamyaing because work was not busy and came back two days ago. When I came here this time, the ticket fare for the bus was the same as before. The bus was the same too. For people like me, it was not a problem. But for those who are younger than me and who are pretty, the person from immigration gave them problems.[26] Though they said that they had their ID cards and were going to meet their husbands, they were not allowed to pass. They were told that they were young, they were pretty and were to be left behind. Then the girls didn't want to get out of the car. Then they give money under their hands. Then they were told that they knew the rules and they asked them to get into the car again. The fare for the car didn't change, and the driver said that the car ticket fee was the same but you have to be responsible for anything on the way like having or not having your ID card with you. On the way, I found that there are rules that say we can carry some goods, like peanuts and onions, they are allowed. But on the day I came, they confiscated them in surprise. There were*

several for each car. You can imagine it – the drivers get 4,000 kyats for each bag and because these goods are allowed, it's ok for them and they make it. Then, when they were confiscated in surprise, the traders lost all. There were mountains of confiscated peanuts and onions. That's what we saw this time."

An initial amount of money of approximately 10,000 to 30,000 kyats (about 400 to 1,200 baht), is required to facilitate migration to Thailand. The total amount is dependent upon the distance, mode of transportation and unforeseen expenses. The migrant population is at the mercy of the police and security forces stationed along the roadway between major trading centres and towns in Myanmar. Identification cards and the general appearance of the migrant are analysed scrupulously. Without cause, officials may find fault and turn the migrant away or require a "tax" that can be paid to the official, the latter seeming to be the norm.

Pattern of Migration

The pattern of migration is about responsibility, duty and hope for a better life. It is dictated by employment and opportunity and different from the stories told by migrants fleeing injustices. Though both groups are migrants in a foreign land, the respondents employed at the factories, brothels, bars and farms throughout Tak Province are provided with a much greater flexibility and freedom of movement than Myanmar refugees and displaced persons. Migrants travel monthly, usually coinciding with the day they receive their pay, to Myawaddy to purchase goods, use the government phones to call their family, deposit savings into a bank, take part in celebrations and visit temples. This is a constant practice of the migrant community, and some even take weekly journeys back home.

Factory workers in particular make yearly migrations, generally during the factory's low season between December and February. They return to their homeland to visit relatives, get married or to deliver their children. Their true intent and aspirations behind working in Thailand are often to establish a sum of capital with which they can create opportunities in Myanmar and provide for their dependents. One female factory worker said: *"We came here not for a visit but because of economic reasons. If we were ok in the lowland we wouldn't come here. We had to work. With good fortune and hard work those with capital return home. I worked here for about three years and then went back and stayed there for one year. Then I came back again."*

Though the qualitative research found detailed information concerning migration patterns, the quantitative research discovered that 39 per cent of females and 31 per cent of males had never returned to Myanmar, though the distinction between monthly journeys to Myawaddy and those back to their families home was not made. Of those who have returned to Myanmar, 36 per cent of males returned once or twice and 16 per cent three or four times. Twenty eight per cent of females returned once or twice and 17 per cent three or four times.

Of the 819 respondents comprising the sample, 85 per cent of females and 62 per cent of males stated that the reason for their return to Myanmar was to visit family. Rest and

relaxation was given by 34 per cent of males as their primary reason for returning home, whereas only 11 per cent of females gave this reason. From the qualitative component of the study, other reasons given for returning home were the inability to find work, instability of work and loneliness.

Employment

Contacts to Ease Migration and Facilitate Entry into Occupation

Factory workers are predominantly recruited by friends, siblings and relatives through word of mouth. As there is a high demand for such work and the pay is a substantial increase from that received for work in Myanmar, the factories need to do little more than announce to their employees that recruitment would take place or positions would become available.

Since the news of factory vacancies is well known to the employees and disseminated well in advance, the workers have time to share the news with friends or relatives who have been eagerly awaiting this opportunity.

Survey results demonstrate 37 per cent of females and 49 per cent of males heard the news of vacancies primarily from their friends. Other ways in which respondents heard about vacancies were through siblings and relatives and scouting for their own factory employment (ranging between 15 and 20 per cent for each method within each gender).

Qualitative research highlights that many of those who migrated to Thailand to work in factories came with a companion who had prior working experience in the area and who had contacts in the town and factory, allowing for a much easier transition. It is not uncommon for one sibling or friend to work in a factory in Thailand and to return home and bring those closest to them back to work in the factory. A female factory worker said: *"We have four girls here, and the eldest sister is married and she's in Myawaddy. She sells goods, and the other four work here in the factory.*"

Of those interviewed by quantitative means, 52 per cent of females and 55 per cent of males said that they had relatives living in Thailand. This points to the large network of Myanmar nationals residing in Mae Sot.

One male factory worker provided his story as follows:

> *"When I first came, I didn't have any difficulty as I came with my aunts who had lived here before. On the way there were no problems. We got tickets to cross the bridge from Myawaddy. When we arrived here the factory didn't make any announcements for workers. After five days they needed workers so I got a job as an intern. I have worked here since then, and it's been over two and a half years now."*

Reliability of Employment

Migrants without any prior factory experience and little knowledge of the particulars of sewing, mechanics or other trade work required by factories may have to wait for extended periods of time before getting their first position. Beginning as an intern at a reduced wage and being trained in the particulars of the factory's trade is not uncommon.

One male factory worker described his story as follows:

> *"We had to wait. We arrived in March 2003, but they stopped calling for unskilled labour. Because I came with my brother the first time, I didn't have my wife with me then so we had to go to the farms and worked there. We worked there until it rained. We grew rice and corn and after seven months we came to this factory and worked in the ironing section."*

Employment in the factory is dependent upon external pressures such as high and low season, demand for goods, need for skilled versus unskilled labourers and ultimately a contact within the factory. Skilled workers who return to their previous employment are given priority, while newly arrived unskilled migrants may have to wait for employment for several months. Those who are taken care of by employed siblings and friends spend their time engaging in social and domestic duties until an opportunity presents itself. Those who do not have the luxury of being supported financially must rely on secondary work as a day labourer or on the farms located on the outskirts of Mae Sot.

Once they have acquired a job in a factory, the migrant workers tend to either retain it or return to it after the low season. When asked about employment prior to their first position at the factory, 73 per cent of females and 49 per cent of males reported that they did not have any prior work. For those who sought other work while waiting for a position in a factory, 18 per cent of males worked on farms and 12 per cent worked in other areas of employment such as construction or as day labourers. Nearly 15 per cent of female respondents worked in another factory and 5 per cent worked either on farms or in some other form of employment, such as a domestic housekeeper.

The following narrative from a male factory worker is an excellent example to demonstrate the lack of stable employment available to the migrant community.

> *"I have been here for seven years. I arrived here in 1997 from Yangon, Tarmwe. I was in the tenth standard, and I failed it several times, three to four. Then I met a broker so I came here. We had three or four girls with us and we arrived here. We each gave about 10,000 kyats to the broker. I didn't get a job when I arrived here. Nobody hired me. Then I spent all the money I had, over 10,000 kyats. Then I met a Thai Chinese lady boss in the market, so I went with her and worked there carrying rice bags. I got 1,500 baht a month. Then I moved to a wool factory for four or five months, then to another factory for three to four months, because the boss didn't have enough money to purchase wool. He let us go without any money, so we had a boycott then."*

> *"I went back to Yangon because I was arrested by the police in Mae Sot. I went back to Yangon and because the economy there was not good I worked in Lin Htat* [in Myanmar]. *I worked there for three months. In 1999 I didn't make much money. Then, one of my friends was dismissed from his job. I went to the boss to discuss my friend. Then I was dismissed too. So we worked in another factory, but the money was not enough for us at that time, it was only just over 10,000 kyats* [per month], *and we had been there for two years. So we came back here in 2002 and got a job in the Mae Tao part* [of Mae Sot District] *in a factory. I worked there and then moved to another factory because of the pay. I worked in that factory for one year. I moved again. I've been over two years in this factory."*

Based on the qualitative research, this mobility between factories is not uncommon and is driven by the migrant's subjective desires, such as higher pay, better working conditions, greater flexibility by management in providing time off and holidays. Once they find themselves in a suitable working environment, workers tend to spend lengthy periods of time working and saving their salaries for their family and future. Both males and females had spent a mean of three years working at their current factory.

Though their migration was facilitated by their desire and need to provide for themselves and their dependents, the research shows that 70 per cent of females and 81 per cent of males did not have a plan for the length of time they would work in the factory. It would be next to impossible, however, to know in advance the number of years needed to achieve financial stability to return to their life in Myanmar. One factory worker said: *"Sometimes we get only 300 baht a month if we have difficulties with the work. Sometimes we get just enough for the curry."*

Permits

Work permits are issued to migrant workers at the request of factory management to the government authority. To be considered for a permit an individual must be sponsored, and in most respects this includes the employer's providing the capital for the permit. As stated previously the cost for a yearly permit is approximately 3,800 baht, and it is expected that the employee would repay the management this sum, usually through deductions from the salary in instalments. The duration of the permit is a maximum of one year, but this can be extended during a month-long registration period designated by the Ministry of Labour every year. The process of registration is complex and time consuming. It involves registration with the police and health office, and the employer receiving a quota from the labour office. One male factory worker described the situation of attaining a work permit: *"In Thailand, there is a system where they issue a work permit. They have three steps. We have to get a police registration record, then we have to go to the hospital to have a blood test and get a card. Only after that will we get a work permit. If we don't do one step, we won't get a work permit."*

The possession of a work permit has both advantages and disadvantages for migrant workers. A sense of ease can be achieved if one has gone through the process of acquiring the work permit, which offers affordable health services, education for migrant

children and safety from the numerous police spot checks inside the factories and along the roadways. One female factory worker said: *"Before we had a work permit we had to be afraid of everything, even if the person who sells* "*nam pla"* [fish sauce] *came, when the dumpling seller came. We were afraid whenever we heard* [the sound of an engine] *because we thought it was a police car."*

The primary disadvantage of possessing a work permit is the resulting lack of freedom and mobility between jobs. As discussed above, migrant workers seek a comfortable work environment that is based upon their subjective desires and standards. With a permit in their possession, it is much more difficult and in some cases impossible to seek out better employment and change factories due to the migrant worker's being indebted to the factory management.

One male factory worker said:

> *"We don't have a work permit so it was very easy to move from one place to another. Because we don't have a permit, we can go anywhere we like. If the factory closes, we move to another factory. The boss can't control us, it's very free for the workers. They can move to another factory if they don't like this factory. Some have been to all the factories in all of Mae Sot* [laughs].*"*

In addition, when one has a work permit, it is only with the permission of the factory management that the worker can be released from their services. One factory worker stated: *"And if the debt for your work permit has been paid and if you don't want to work there, you need to get a release from previous boss."*

Throughout the qualitative component of the study there were mixed responses from factory workers regarding permits. Survey results show that nearly three-quarters of respondents, both male and female, said they were in possession of a work permit (23 per cent of females and 18 per cent of males said they did not have a permit). Perhaps wary of the questioning concerning sensitive permit issues and unsure about the team's intentions, respondents may have felt inclined to falsely report that they were in possession of a permit.

Pay Rate

One female factory worker said: *"No, I have to go back and work there* [Myanmar]. *I have to work for the rest of my life there. I can't stay here. It's just for earning money."*

Nearly three-quarters of respondents are paid their salary at the end of every month. The mean monthly salary of both male and female respondents is nearly 2,500 baht. As workers' specialization skills increase and the factory's product becomes in greater demand, skilled employees can make upwards of 6,000 to 7,000 baht every month.

A worker's pay is dependent upon the specialization of the job and the number of hours worked. Those paid by the piece are usually able to negotiate the price for new items and

patterns. This is not the ideal for the factory management, as skilled male factory workers paid in this fashion seem to be very outspoken and band together to negotiate a fair pay for their work. If the management and the employees cannot come to a mutual understanding concerning a fair price for a dozen items, a price is negotiated. One male factory worker explained: *"We would gather and ask someone who could speak* [for us], *such as the manager, to tell the boss. We negotiate the price. If they don't agree, we boycott. We switch off the electricity and don't work. Then they increase the price."*

During the low season or if difficulties arise and they cannot work, migrants tap into savings that have not already been sent to their dependents. It is common for these migrants to invest in gold or cross the bridge to Myawaddy and open a bank account. Qualitative research demonstrates that if work is consistent and they remain healthy, migrants can save nearly 5,000 baht per month. Several respondents reported sending large amounts of money, often around 20,000 to 25,000 baht, home on a yearly basis. It is little wonder then that migrating to Thailand to work in a factory is so readily attempted and why one finds large numbers of the same family working in Mae Sot District through word of mouth. One factory worker said: *"If* [we work] *here, we can send back 50,000 kyats (around 2,000 baht) a month after accounting for our living expenses. We can't give our parents that if we are in the lowland – we won't get even 10,000 kyats."*

Recreation and Leisure

During the little amount of leisure time the factory workers have, they tend to take care of domestic issues, go to the temple and spend their time socializing with friends and colleagues. A significant amount of this time, usually once a month on payday, is spent on the Myanmar side of the border so they may purchase daily necessities. A female factory worker said: "[We] *buy something we need for our daily lives. Goods for eating, like "na pi"* [pickled fish paste], *dried fish and so on and come back again."* In the evenings those who are not working the overtime shift occupy their time washing clothes, reading books from the factory library and watching television and videos. Male factory workers enjoy playing football and volleyball in the factory yard.

Health and Behaviour

Drugs and Alcohol

Nearly all respondents were aware of the drug "*yaa-baa*." When discussing personal consumption and use of drugs and alcohol, respondents gave different responses from when discussing use by their friends and others. Focus group participants were quick to elaborate on the high use of drugs and alcohol by Thais, Burmese, Karen, Shan and Chinese in Mae Sot District.

According to the survey and focus group discussions, male respondents indulged in drugs and alcohol to a greater degree than females, though mostly on holidays and weekends. Approximately half of males drank before engaging in sex with their regular partner while 20 per cent of married female respondents drank before having intercourse. A very

small percentage of female and male participants had ever used drugs with any type of partner prior to intercourse. Those who had indulged in drugs seemed to prefer marijuana as opposed to methamphetamines.

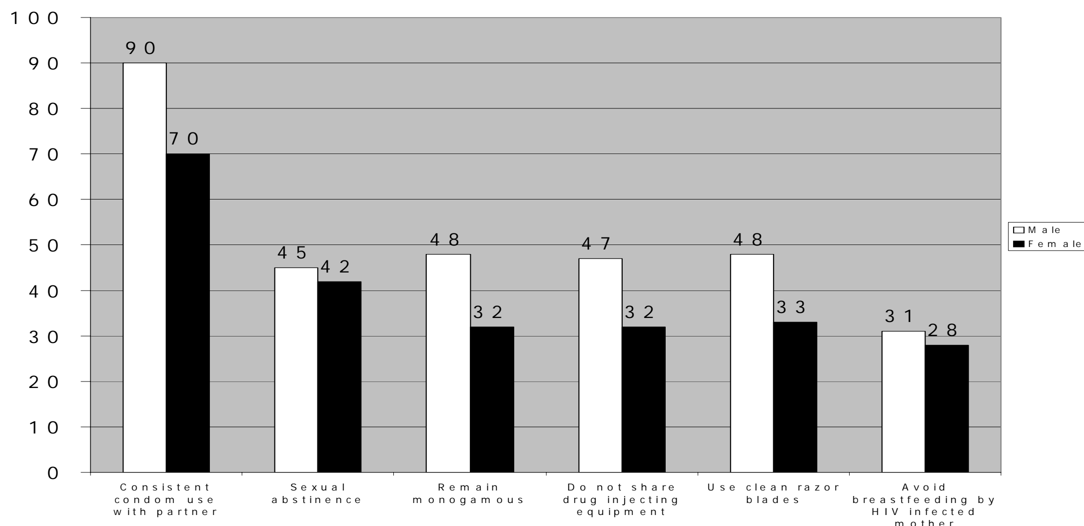
Due to the sensitivity of the topic, during only the individual in-depth interviews did the factory workers reveal the use of methamphetamines, which were administered by supervisors and management to those needing to work overtime to finish quotas. The workers said the drug was usually administered by mixing it with drinking water or soda given to overtime workers. The effects of the drug allowed them to work throughout the evening and into the late hours of the night without tiring, and as a result production increased significantly. As this was not a primary topic of the assessment, further inquiry did not take place. Therefore, these statements must be taken as hearsay and require additional investigation for confirmation.

Knowledge and Attitudes

HIV/AIDS

A series of 15 questions was designed and given to the respondents in the questionnaire to test knowledge of HIV/AIDS. Generally, migrant factory workers have basic knowledge of HIV/AIDS and STIs. A comparison of responses by gender is contained in Figure 1. As a whole, males demonstrated greater knowledge in the areas of transmission and prevention.

Figure 1. HIV Prevention Methods Known to Migrant Factory Workers



The best known method of HIV prevention is condom use, though as demonstrated in Figure 1, only 70 per cent of females knew that consistent condom use with their partners was a form of HIV prevention. As a whole, knowledge remains low in all methods

discussed, especially among females. An alarming find was that all methods outside of condom use were generally at or below 50 per cent for both males and females.

Regarding transmission and highlighted in the qualitative component of the study, both males and females seem to be of the opinion that HIV is predominantly acquired due to men having sex with *"bad women"* or "*sar"* as they are called among the migrant community. As sex workers are in a high-risk profession in which HIV can spread through a population, there seems to be much less knowledge of other methods of transmission.

The following are the greatest misconceptions among sampled males:

1) over 40 per cent feel that HIV can be transmitted through being bitten by a mosquito;
2) almost 30 per cent believe that a healthy-looking person cannot transmit HIV to their partner;
3) nearly 30 per cent of single males believe that they cannot protect themselves by having sex exclusively with one faithful, uninfected partner;
4) nearly 90 per cent believe that there is medicine that can cure HIV/AIDS; and
5) almost half are unaware there is medicine available to help reduce the chance of HIV infected persons falling ill with AIDS (i.e., antiretroviral therapy [ART]).

The following are the greatest misconceptions among sampled females:

1) two-thirds believe that HIV can be transmitted through being bitten by a mosquito;
2) over half believe that a person cannot become infected with HIV by having sexual intercourse;
3) only 32 per cent believe that a woman with HIV can transmit the virus to her newborn child through breastfeeding;
6) nearly 80 per cent believe that a healthy-looking person cannot transmit HIV to their partner;
7) 70 per cent believe that they cannot protect themselves by having sex exclusively with one faithful, uninfected partner;
8) nearly 90 per cent believe that there is medicine that can cure HIV/AIDS ; and
9) over 80 per cent are unaware there is medicine available to help reduce the chance of HIV infected persons falling ill with AIDS (i.e., ART).

Most male and female respondents felt they were at a low risk of contracting HIV, with only 11 per cent of single females and 7 per cent of single males feeling they were at a high risk of contracting the virus.

Qualitative interpretation revealed that most migrant factory workers had either no knowledge of or very basic information about HIV/AIDS prior to their arrival in Thailand. Those who said they had heard of HIV or AIDS back home had merely heard the name or had received some information from media sources. One male factory

worker said*: "In Myanmar we have radio stations that broadcast about it. They said that there's no medicine to cure AIDS."*

Survey results demonstrate that 23 per cent of married males and 17 per cent of single males had never heard of HIV or AIDS prior to their arrival in Thailand. Female respondents arrived in Thailand with less overall knowledge. Approximately 30 per cent of married and single females had no knowledge of HIV or AIDS when they resided in Myanmar.

Once established on the Thai side of the border and integrated into the migrant community and/or work force, their exposure to HIV and AIDS interventions through mass media, prevention programmes and health services provided their initial understanding of the gravity of the disease and its routes of transmission. One male factory worker said: *"Only after I arrived here, did I see it in readings and pictures and I understood more. The elders are the people in our wards, they said that we could contract infections if we go out."*

Sexually Transmitted Infections

Eight per cent of married female respondents and 2 per cent of married male respondents reported having foul-smelling discharge within the past 12 months, demonstrating that STIs, though present in the community, are not a large issue regarding migrant health.

During focus group sessions, participants did not recognize the term STI (when translated into Thai) used by the facilitator, and it was only once the facilitator used the local, or colloquial, terminology for STI (*ka la thar yaw gar*) that participants understood. Based on qualitative findings, individuals infected with an STI are commonly referred to as being "*broken*".

Knowledge of STIs among survey participants is low, with 52 per cent of males and 32 per cent of females saying that they did not know of any disease other than HIV/AIDS that could be spread through sexual contact. Compounding the issue of low knowledge, almost 30 per cent of female respondents did not agree that a person suffering from an STI had a higher chance of HIV infection.

When female respondents were asked to name all male and female symptoms of STIs, the main selections they made were foul-smelling discharge, burning/pain during urination, and genital ulcers or sores. Though these three were selected at a higher frequency than all other symptoms listed, they were selected less than 25 per cent of the time. Similarly, males chose two or three primary symptoms out of a list of nine common STI symptoms. There was little difference between married and single men's selections. Nearly 60 per cent of sampled males felt that genital warts and skin rashes were the most common symptoms of women with an STI, while over 15 per cent selected burning during urination and genital sores. Concerning male symptoms, 57 per cent of men selected skin rashes as the primary symptom, with genital sores (27%) and burning during urination (22%) selected as the second and third most common symptoms.

Condom Use and Sexual Behaviour

Though the availability of condoms and the promotion of their use is high in Thailand, 22 per cent of married females, 26 per cent of single females and nearly 10 per cent of single males have never heard of condoms. When asked if people could protect themselves from HIV by using a condom correctly every time they had sex, over 37 per cent of females and over 21 per cent of males said they did not believe condoms could provide this protection.

Condom availability within the factory and throughout health facilities is high, and perhaps justified by 95 per cent of men suggesting that a condom could be procured easily if needed. Conversely 14 per cent of women said that condoms were not easily procured.

Male and female respondents are aware of where to find condoms locally, which is predominantly in drug stores and government hospitals. Male respondents chose grocery stores and health centres as other potential procurement options, while females said they also obtained them from health volunteers. Encouragingly, nearly 70 per cent of males and females disagreed with the statement that only a man could procure a condom.

Survey participants were asked to list all known purposes for condom use. Respondents replied that their main uses were for the prevention of STIs and as a form of contraception. Protection from HIV was selected by only roughly 40 per cent of men and nearly 30 per cent of women.

Not surprisingly condom use among married couples and regular partners is rare, with only 12 per cent of married women ever having used a condom with their regular partner. Interestingly, nearly 45 per cent of married men said they had used a condom with their regular partner, though the predominant use in this context, which was confirmed through qualitative methods, would be as a form of contraception.

Rates of condom use by single females cannot be deemed representative due to only 1 per cent of single females reporting having ever engaged in sexual intercourse. Fourteen per cent of single males reported having had intercourse previously, of which nearly 85 per cent reported that they had not had a regular partner. Of those with a regular partner, only 44 per cent reported ever having used a condom when having sex.

Single males who did not have a regular partner also reported that they had not had a regular partner within the previous year. Due to skips in the questionnaire, those who said they had a non-regular partner amounted to only six respondents out of the total male sample size of 312, and as with single females, must not be understood to be representative.

When negotiating condom use with their regular partner, over 70 per cent of male respondents said they would accept having sexual intercourse without a condom if their

regular partner refused to use one. Females offered a varied response with close to 40 per cent saying they would accept non-use, while 31 per cent stated that they would discuss using a condom with their partner until they accepted using one.

Nearly 70 per cent of married men and 60 per cent of married women said they could convince their regular partner to use a condom, and only 40 per cent of women and 44 per cent of men felt they could deny their partner sex if they refused to use a condom. A greater proportion of men than women felt that using a condom would reduce pleasure.

Results show that there were several issues that may restrict condom use. Males discussed issues of laziness when needing to put on a condom or having to discard it when they were tired after intercourse. Perhaps more to the point is the matter of privacy and embarrassment surrounding procuring a condom in the factory and trying to discard it discreetly while sharing a dorm room. One male factory worker said: *"Here we are afraid that others might laugh at us. Even when we want to use it, we are afraid that people might tease us. Here information spreads very quickly."*

Sex workers were rarely enlisted for their services – only 4 per cent of single males reported having engaged in such activity in the past 12 months. In the focus group discussions, however, several male factory workers demonstrated knowledge of the types of sex workers in Mae Sot (i.e., brothel-based, karaoke and freelance).

Apart from the relatively low frequencies, the qualitative research was able to attain greater details that provided much needed contextual information on factory workers' sexual behaviour and situations.

As the factories usually have large compounds and are located on the outskirts of the town, couples can find time to disappear into the wooded areas of the compound for a more intimate and private environment. A female factory worker said: *"We call it the banana forest. They go inside that banana forest, under the banana trees."*

Though HIV vulnerability may not presently be very high due to cultural factors, the length of working hours and the lack of free time, there are nevertheless opportunities for workers to socialize and engage in sexual activities. Working in a mixed factory environment it is natural for men and women to engage in forms of flirtation. One male factory worker described the situation:

> *"The nature of the work here is that sometimes the man and woman have to sit facing each other and work on the work table, like we sit here now. So, even if you are very restricted, you have to ask the person in front of you if you don't know something, and chat sometimes. Then the girls can ask for help, such as "big brother accompany me to the market" and the man can say "young sister, let's go to the pagoda today" and when they go in couples to some places where there are fewer people, then there might be some touching. So it can happen anytime."*

Upon the initial visit to Mae Sot there were discussions surrounding female factory workers working as freelance sex workers inside the factory, or more commonly known as an *"open book account"*. One male factory worker described the situation: *"She had a monthly pay book and recorded in it the number of people who owed her."*

Through qualitative research, the existence of these women was confirmed, though according to factory workers this was quite rare due to management policies and the close-knit environment of the factory workers. Much like a small village, people begin to talk and without much effort the news of these women spreads very rapidly with the end result being their dismissal by factory management. Rarely do these women last more then a few months working in the factory.

One male factory worker described such a situation regarding one woman working in the factory:

> *"I used to hear from the others [about her], but not now. She looked like a wife of a Burmese official – she was very beautiful. Others called her "The Book" but I didn't know about her. So, I asked them what "The Book" was. They said that [she was] a girl who had a book where she noted the men who slept with her. Then she collected the money at the end of the month. So they had to pay her. But she was chased away later."*

Exposure to Mass Media, IEC Intervention and Outreach

Past IEC and outreach programmes have proven to be an effective means of disseminating knowledge and promoting safe sexual behaviour.

While discussing HIV/AIDS, one male factory worker said:

> *"They said it depends on our behaviour. We have to be careful in our behaviour. I also heard that if the body's resistance is good and we have good and normal eating habits, then the infection can persist for five to ten years and nothing will happen to the person. It's your behaviour. If because of the way you live and eat you become malnourished, the germ is the one that destroys the body's resistance, so your body's defences will become reduced and there will be many infections such as TB, malaria, diarrhoea, and many [other] infections. Because this germ is undermining the defence mechanism, the main symptoms are not due to this germ but due to the other infections. The germ just destroys the body's defences. Other infections will come if there's a chance."*

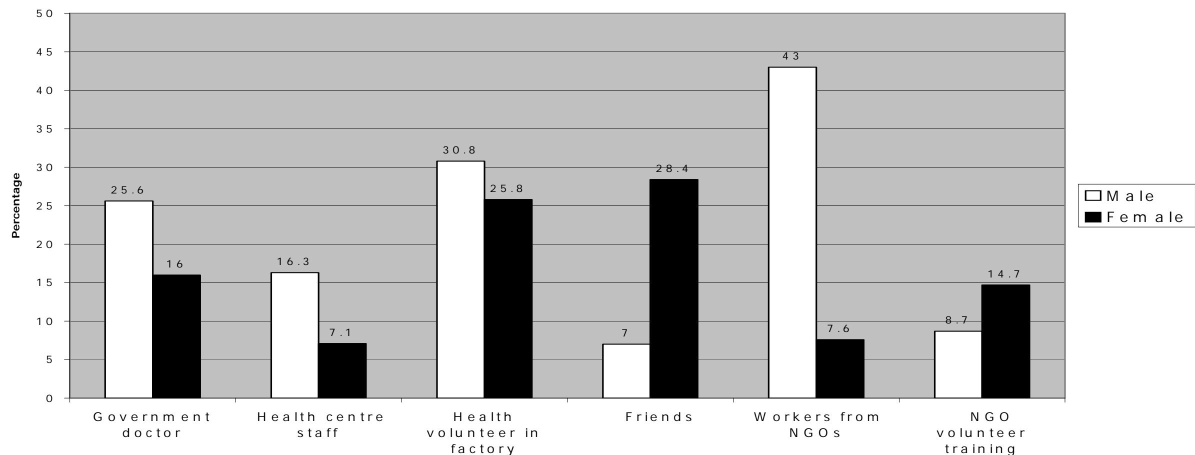
Respondents were asked if they had ever received any information or attended any training on HIV/AIDS/STIs within the past 12 months. Seventy-two per cent of married males and 51 per cent of married females reported that they had attended some training or received some information on HIV/STIs. Less than half of the single males and females had participated in HIV-prevention programmes through outreach interventions or other means. Trainings within the community can be somewhat sparse and very few factory

workers have been selected to attend such training, as they would not be able to work during the training. Interventions therefore tend to rely on information from their peers and the ability of those who attended the training to return to the factory and disseminate the information. One female factory worker said: *"We didn't go at that time. But about five people from the factory went to the meeting and listened to the talks on AIDS. We didn't go because they were selected by the managers. They have to find those who have less work because they are afraid that the work might be late."*

Those surveyed were asked to name all the ways in which they received information on HIV/AIDS/STIs. Figure 2 demonstrates the primary sources of this information. Males predominantly receive this relevant health information through government doctors, health volunteers in the factory or NGO workers. Females on the other hand receive information through friends and health volunteers in the factory.

Forms of mass media (such as television programmes broadcasted from Myanmar) and publications (brochures and posters) in the Myanmar language are the primary modes of disseminating the information. One female factory worker said: *"When I read the book I learned about it. We heard of these infections and HIV/AIDS because someone came and delivered pamphlets and we read some books."*

Figure 2. Primary Source of STI/HIV/AIDS Information for Factory Workers



Factory workers acquire knowledge on proper condom use and HIV/AIDS/STIs mainly through television, posters and brochures. Married men were more likely to have received some form of training than either married or single women. Less than half of all female and single male respondents attended some form of intervention focusing on condom use and HIV prevention within the last year.

Males tended to acquire their information from NGO workers, village health volunteers, government doctors and health centre staff. Female factory workers acquired such information from similar sources, though also relied on friends as a source of knowledge concerning condoms and HIV prevention.

Contraception

The migrant community has a strong understanding of contraceptive methods. Both married men and married women are more knowledgeable than single women, of which 42 per cent did not know of a contraceptive method to prevent pregnancy. Thirty per cent of single men did not know of any contraceptive methods.

Contraceptive methods known to males and females included oral pills and injections. Nearly 90 per cent of males but only 41 per cent of females reported knowing of condoms as a form of contraception.

Health Services and Health Seeking Behaviour

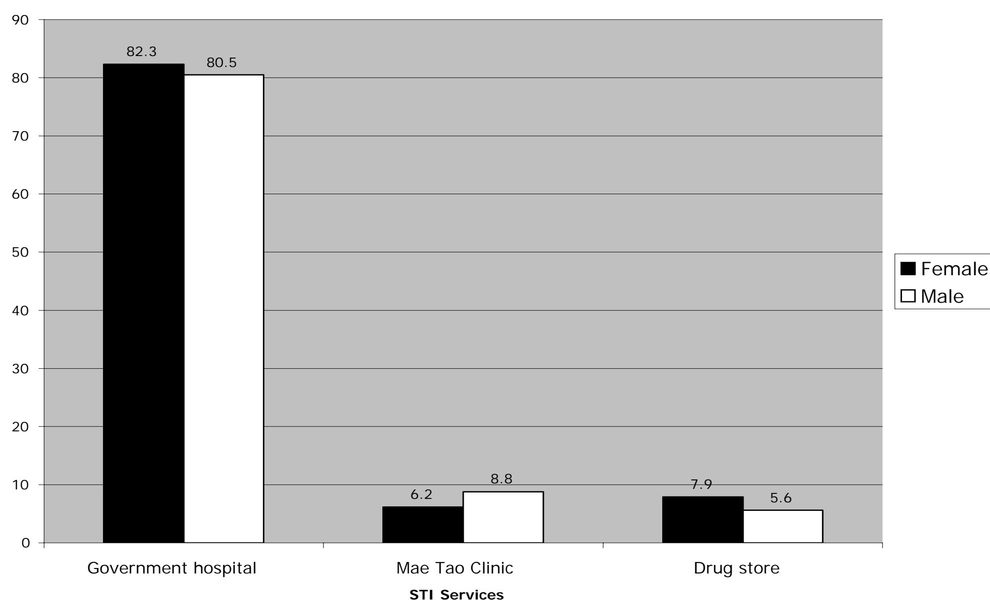
As a whole, respondents felt that the quality of treatment and services at Mae Sot General Hospital was relatively high. For treatment of illnesses, migrant workers access three primary service providers available within Mae Sot District – the government hospital, private clinics and the Mae Tao Clinic, as highlighted in Table 5. The Mae Tao Clinic, dedicated to catering specifically to the health needs of the migrant community was surprisingly not the primary destination for the sample population, especially for men. This may be due to the fact that the selection of a health treatment facility for the migrant community is greatly restricted based upon their legal status in Thailand. A female factory worker said: *"We go to the hospital if we have a work permit, and we go to the students' clinic* [Mae Tao Clinic] *if we don't have a work permit."*

Table 5. Health Service Providers for Factory Workers (multiple answers possible)

Service Provider	Male		Female	
	Percentage	Number	Percentage	Number
Government hospital	51.1	159	39.1	198
Mae Tao Clinic	37.2	193	20.7	105
Private clinic	3.9	66	6.7	34
Private hospital	1.3	12	0.6	3
Traditional healer	0.6	1	1.0	5
Health centre	0.0	0	1.2	6

Based upon the evidence contained in Figure 3, male and female respondents overwhelmingly prefer the STI services offered at Mae Sot General Hospital. Qualitative research shows that due to the sensitivity of sexual health and the potential for the patients to be seen by friends and colleagues at the Mae Tao Clinic, respondents prefer the anonymity found at the Mae Sot General Hospital. This anonymity far outweighs the difficulties concerning the lack of a common language at the hospital.

Figure 3. Primary Selection of STI Services for Female and Male Respondents



Regarding HIV/AIDS services, two essential questions, as seen in Table 6, were raised. Divergent opinions emerged between male and female factory workers concerning what they thought the possibility of receiving a confidential HIV test was. Less than half of the female respondents thought it would be possible for the test to be administered confidentially. Along with this essential result, Table 6 demonstrates that over 30 per cent of male factory workers and 40 per cent of female factory workers did not know of any facility in the area where one could receive an HIV test.

Table 6. Perceptions of HIV Testing (% of Respondents Who Responded Favourably)

	Male		Female	
	Married	Single	Married	Single
Do you know any facility in your area where you can get tested for HIV?	67.2	66.4	59.3	61.1
Do you think it would be possible for someone to get an HIV test done confidentially?	83.3	78.3	40.6	43.5

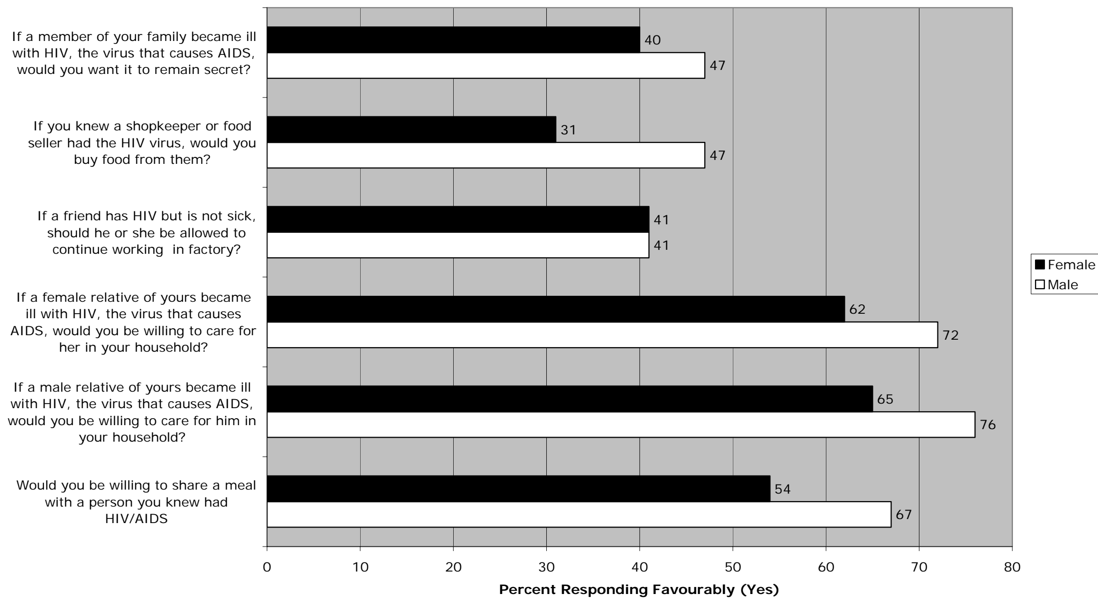
Reproductive Health of Females

The questionnaire given to the female factory workers included questions regarding reproductive health. Information from the questionnaire shows that 61 per cent of married women had already had at least one child. Approximately three-quarters of mothers sought antenatal and post-partum care at a government hospital (in either Thailand or Myanmar) for their youngest child. Sixty-seven per cent of married women delivered their children in a government hospital while 19 per cent had enlisted the services of a traditional birth attendant. Only one-quarter of married women delivered their youngest child in Thailand, confirming that the vast majority of pregnant women return to Myanmar to deliver their children.

Stigma and Discrimination

Issues of HIV/AIDS stigma and discrimination among factory workers were included in the final section of the questionnaire. Figure 4 shows the answers to the six questions asked to gauge the migrant factory workers' attitudes and levels of tolerance.

Figure 4. Male and Female Attitudes towards People with HIV (Stigma and Discrimination)



Interestingly, the results demonstrate that as HIV infection is found closer to home (i.e., in a family member), the respondents are more accepting of people living with HIV/AIDS. Males on average had a slightly more positive attitude towards those with HIV/AIDS, perhaps partly due to the higher percentage of HIV/AIDS knowledge found among men. Though some results are somewhat encouraging, stigma and discrimination remains an issue that merits additional and ongoing intervention.

6. RECOMMENDATIONS

Though the assessment provides a picture of migrant sex worker and factory worker knowledge and behaviour as it relates to HIV vulnerability, it has also evoked many more questions that need to be addressed and further researched.

Accepting those biases discussed in this report and assuming the data collected is correct, IOM and the Provincial Health Office, among other diligent local and international organizations in Mae Sot District, have the opportunity to assist in maintaining low-risk behaviour among factory workers, continue strong outreach and expand clinical services for the direct and indirect sex work community, and improve that which is truly an indicator of these two selected migrant populations' HIV/AIDS vulnerability – low HIV/AIDS knowledge.

Programme Intervention and Policy-Related

- Utilize Myanmar speaking staffs and develop IEC materials in Myanmar for effective communication

As the study shows, most migrants interviewed face language barriers in various occasions including access to healthcare information. In fact, the majority of migrant workers interviewed stated that they were unable to speak any Thai even they live and work in Thailand for many years. Thus, communication in the migrants' common language is one of the most important components for project implementation.

- Support family and peer communication on sexual health issue

The study found that many migrants in Mae Sot have closely knitted network based on kinship and friendship and tend to rely on this network, from crossing borders, finding jobs, to health information such as vaccination opportunities. Therefore, interventions targeted at interpersonal network, running through a small channel, could generate a snowball effect and be effective.

- Support eligible migrants to register and acquire health insurance

With the proper documentation (a registration record with the police and a health check-up certificate, which are also the documents required to apply for a work permit) migrants can acquire the health insurance card, enabling them to receive health services from Mae Sot General Hospital and associated health centres through Thai social security or the "30 baht scheme". However, this policy excludes those who are not in possession of proper documentation, which is a large proportion of the migrant population residing in the area.

- Examine healthcare financing options to cover both documented and undocumented migrants

Although it is preferable to have all migrants registered but it is impractical in real situation. Undocumented migrants often face difficulties to access to health services. It could be concerned as alternative way for those with no document to have another health scheme from health service providers.

- Increase access to and awareness of voluntary confidential counselling testing

About three-third of migrants in the survey did not know of any facilities in the areas where one could receive an HIV test. The hospital and health care providers should promote the services in addition to aware of the confidentiality of the test.

- Provide anonymity in the hospital and other health service providers regarding sexual health

Due to the sensitivity of sexual health and the potential for the patients to be seen by friends, the hospital and other health service providers should concern on the anonymity of patients. Migrants in Mae Sot mentioned preference on the anonymity found at the Mae Sot General Hospital as they could be anonymous there.

- Improve the capacity and health communication skills of health personnel

Health personnel should be trained and update in matters of HIV/STI sensitization, discretion, counselling and confidentiality as they would be potential and reliable channel to deliver messages and services to migrants. However, the study found that some migrants have experience with health personnel's insensitive behaviours to them. Migrant community health worker should be involved in providing counselling, peer education and translation as well.

- Strengthen multi-sector network and coordination on migrant health

Create a strong multi-sector coordinating body on migrant health and related issues among government, NGOs and community-based organizations as a variety of organizations work on migrants' health issues in the areas studied. The government organizations and NGOs in the transit and return communities (e.g., in Myawaddy) can coordinate and strengthen the source-transit-destination linkage for a more collective response.

- Raise awareness about health and safe migration

Intervention could be during pre-departure and transit and at destinations in Thailand, using radio, outreach, targeted IEC and other strategies. Partner with agencies in the non-health sector and focus on raising awareness of migrant worker registration, human rights and obligations of the migrant, and vulnerabilities related to legal status, lack of empowerment, etc.

Interventions with Sex Workers

- Increase knowledge on HIV/AIDS/STIs and support positive attitude on condom use

Qualitative data from interviews show that most migrants including sex workers do not have much knowledge and information on HIV/AIDS/STIs before coming to Thailand. They may not even know how to use condom correctly. If the intervention project could provide training session and IEC materials with necessary information in their language, they would have more information and practise safer practices.

- Improve and increase negotiation skill for sex workers

Condom use is variable and dependent upon the attitude of the user and partner who are varied in age, ethnicity and occupation. As revealed in one of the interviews, sex workers

are often powerless to negotiate with the clients in many circumstances while they are forced by the employers to please the clients. It is crucial to enhance the negotiation skills among sex workers that they can talk about condom use with the clients. The way to put condom on could be trained as tactical methods to the sex workers. This would also help decreasing barrier on communication/languages between sex workers and clients on condom use as well as dealing with a drunken client.

- Promote condom use with the clients and partners of sex workers

Because reinforcing sex workers' proper use of condoms does not work if their clients/ partners do not cooperate, interventions are also needed among clients/partners of sex workers, especially when the clients are from Myanmar such as those of the Kayin ethnicity, who according to the study, are less inclined to use condom. The appropriate information on condom use should be provided to the clients/partners of sex workers as some of them, especially Chinese and Thais, still have misconception on condom use, i.e. use two condoms at a time for dual protection.

- Promote condom use as a "*norm*" for all types of sex partners

Sex workers are encouraged to use condoms with the clients for their work. However, interviews revealed that they rarely used condoms with non-commercial partners as they do not perceive it as doing a job. The sex workers may not use condoms with regular partners as well when they feel in relationship. In this sense, condom use could be promoted as a tool of care as well as a tool of HIV prevention.

- Promote lubricant use with condom

Promote lubricant use among sex workers as another way to reduce their vulnerability and susceptibility to STIs and HIV since the findings in interviews show that they are concerned about condoms breaking due to the injection of oil or other fluids for enlargement of the penis as well as the fact that many of them have sexual intercourse many times per night.

- Coordinate with employers of sex worker to support condom and lubricant use

With regards to preventing HIV/AIDS/STIs and promoting knowledge of these diseases, it is advantageous if the boss or employer is in the habit of promoting condom use and asking the women to protect themselves as some sex workers suggested in interviews that they use condoms because their boss tell them to use. In addition, if it is the policy of the employer, the sex workers will be more active to use the condom in any situations. They could also supply the condom and lubricant at their places that they can get it any times they want.

- Increase the use of peer education in workplace

Findings suggest that the sex workers are often not open themselves to community and

thus do not want to access any health services if not in critical situation. Therefore, the peer education can be a potential strategy to reach and provide necessary information to them as a role model among sex workers.

- Design different approach/intervention to access indirect sex workers

Although the indirect sex workers are hidden population, it is known that they work mainly in the karaoke establishments that could be approached. They had much lower number of clients than direct sex workers, but more of them tended to have "sweatheart," whom could be considered as the "bridging populations" between high-low risk groups. Indirect sex workers were less seen at the "hygiene clinic" which further marginalized them from the HIV/STIs services. Intervention project should design the different approach and interventions to provide knowledge and necessary skills to them. Other issues i.e. occupational training, that are in their interests could be incorporated in the training session to attract them.

- Expand health services and interventions among indirect sex workers

Continue government and NGO clinical and outreach interventions with direct sex workers and expand coverage among indirect sex workers and improve communication strategies. According to the study, few indirect sex workers attend the weekly clinic. If they are not attached to a brothel or bar where the employer promotes positive personal hygiene and health, there is no policy or outreach in place to target these women. However, they are still in active sexual network that can spread and/or receive HIV/STIs widely.

Interventions with Factory Workers

- Raise awareness on sexual risk after taking drugs or alcohol

Most of migrants are aware of using drugs and alcohol in the community. Many of them accept having sex after drank especially male migrants. In fact, approximately half of males studied drank before engaging in sex with their regular partner, while 20 per cent of married female respondents drank before having intercourse. They would be less conscious to think about practicing safer sexual behaviours; regarding type and number of sex partners, and using condom which could lead to sexual risks. Intervention project could raise migrants' awareness on this issue that they need to prepare and be aware of the consequence.

- Provide necessary information on HIV/AIDS/STIs and condom use

Results from the survey present a low level of knowledge on HIV/AIDS/STIs among migrants. For instance, 22 per cent of married females, 26 per cent of single females and nearly 10 per cent of single males have never heard of condoms, implying they do not have any information and do not protect themselves respectively. In addition, those who know about HIV still have misperceptions. For instance, 40 per cent of males and two-

thirds of females sampled think that HIV can be transmitted through being bitten by a mosquito. A set of necessary information package on HIV/AIDS/STIs and condom use should be disseminated to migrants in workplaces and community.

- Inform about possibility of getting HIV from every types of partner

Both male and female migrants seem to be of the opinion that HIV is predominantly acquire due to men having sex with sex workers, “bad women” or *sar* as they are called among the migrant community. Then, there seems to be much less knowledge of other methods of transmission and other type of sexual partners. Information on sexual network and risk should be provided to migrants through any effective channels.

- Encourage condom use in sense of care and protection of pregnancy and diseases

The survey results show that migrants have different perspectives of using condom with different types of partners. They use condom with non-commercial partners for contraception while use condom with commercial partners for prevention of HIV/STIs. These common attitudes should be supported. That is encouraging using condom with non-commercial partners for sense of caring and contraception. It is no need to link condom use with HIV/STI prevention every time when promoting condom use.

- Encourage friends to support friends to use condom

There are several issues that may restrict condom use, including laziness, discarding, pleasure, and embarrassment. Friends can support condom use and overcome those restrictions, especially for female workers as the findings show that they rely their condom and HIV knowledge on their friends. In social environment, some migrants show embarrassment to procure condom. They told that they become reluctant buying or using condom because their friends might laugh and tease about condoms. On the other side, the same friends can be used as a strategy for social support for using condoms.

- Personalize HIV risk and raise individual’s awareness

As the survey indicates that many migrants do not understand about HIV well, they feel they are at a low risk of contracting HIV. They think that HIV is far from them, then it is unlikely for them to protect themselves. It is important that implementation project provide some information to help them understand the disease and aware of self-risk.

- Target both males and females using different gender-appropriate strategies

Sexuality is a sensitive issue among different genders. In particular, the study found that females are more likely to be obstructed from public activities providing information on sexual-related issue. For information dissemination channel, males predominantly receive relevant health information through government doctors, health volunteers in the factory or NGO workers. Females, on the other hand, receive information through friends and health volunteers in the factory. However, both male and female should have equal

opportunities to receive the information from professionals and public as they are at equal sexual risk.

- Refresh and conduct the training and intervention periodically

As this study revealed that migrants have a high turnover rate and frequent change of workplace refreshment training and outreach related to basic and sexual health care including HIV and STIs should be conducted periodically – perhaps semi-annually – to ensure the migrants receive information needed even though they are not at high risk.

- Increase the use of peer education in outreach and in clinical settings

Past IEC and outreach programmes have proven to be an effective means of disseminating knowledge and promoting safe sexual behaviour, though the findings show that less than half of the singles had participated in HIV-prevention programmes through outreach interventions or other means. Intervention project should cover the implementation in all areas and regularly. Peers could be a potential channel to deliver safe sex messages to factory workers.

- Work with factory management to bring timely and repeated outreach trainings to a greater proportion of factory workers

Trainings within the community can be somewhat sparse and very few factory workers have been selected to attend such training, as they would not be able to work during the training. Interventions therefore tend to rely on information from their peers and the ability of those who attended the training to return to the factory and disseminate the information.

- Strengthen the involvement of factory management in interventions to create an enabling environment for improved health

Migrants take most of their time in the factory. Some lives in factory compound as well. The factory management should be involved in the interventions. They would not support the workers to participate the training sessions only but could have policy to promote healthy environments in the factories also.

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