Women, Mobility and Reproductive Health

GAATW

Global Alliance Against Traffic in Women

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The Assessment of the Circumstances of Mobility and Reproductive Health Needs Among Women Migrant Workers in Thailand

GLOBAL ALLIANCE AGAINST TRAFFIC IN WOMEN
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CONTENTS

EXECUTIVE SUMMARY

The health conditions and mobility patterns of female migrant workers are subjects that sit at the crossroads of multiple pressing issues, best understood in the context of social, economic and political disparities in the global landscape. Remaining outside of legally protected industries, women migrant workers are isolated from mainstream labor and social and health protection policies. The vulnerability of migrants, in this case women from Laos, Burma and Cambodia, is accentuated by one or more of the following reasons: inability to communicate in the dominant language, rapid changes in domestic and international migration policies, and facing discrimination on a routine basis. In addition, migration patterns of women are often affected by gendered occupational demands. This research focuses on domestic, factory and sex work – all of which are typically underpaid, characterized by poor working conditions with little or no protection from the state. The comprehensive mapping of the occupational lives of migrant women realized through both qualitative and quantitative research frames the discussion on how occupational demands impact on the general and reproductive health of migrant women. The analysis and findings of this research are meant to provide information and support to Thailand's national HIV/AIDS control program for a more sensitive and responsive implementation of their outreach operations. In addition, these are also meant to inform the practice of policy makers, health care providers, and organizations working with migrant women.

To most women domestic work seemed a good way of finding a foothold in a foreign land and afforded advantages in the form of some security, a place to stay and food to eat. But domestic workers were also isolated from the rest of the migrant community due to the nature of their work. This made their situation more vulnerable when faced with physical and mental abuse. Health outreach campaigns were also not accessible to them as a result of their isolated existence. Their long work hours and sheer physical labor in fact necessitated more health awareness programs, especially pertaining to reproductive health, as many were in their reproductive age. Psychological health was identified as another important area that needed attention. Feelings of isolation and depression were more commonly reported by domestic workers. The fact that the domestic labor industry in Thailand is much less formalized than factory work is also instrumental in accentuating their insecurity and anxiety about work.

In the case of factory workers, this research has focused on specific factories as migrants of particular nationalities tended to find employment in certain types of factories. Lao workers were apt to find employment in the food processing industry, the Burmese workers were mostly into

the garment industry while the Cambodian women migrants had jobs in fishery-related industries. Factory workers' health was noticeably affected by the occupations that they were involved in. A definite link was observed between the conditions in which the migrants worked and the symptoms they developed. Crowded living quarters, substandard food, limited access to safe drinking water and to toilets during work hours had a debilitating effect on health. Discussions with women brought to light the fact that most preferred speaking to local healers and using herbal medicines and traditional practices for problems pertaining to sexual and reproductive health. Since this is a significant finding, the researchers have made a strong recommendation that the knowledge be documented as it serves to complement modern medical knowledge.

While sex workers were found to be more mobile than domestic and factory workers, it was by and large true that they depended on the employer for their safety, protection from abusive clients and for regular STI check-ups. This gave scope to employers to exploit the situation by exercising control over time and earnings. Despite the fact that sex workers in Thailand have been the focus of educational and outreach programs, many participants in this research reported information gaps on HIV, menstruation and conditions like cancer. Moreover, occupational demands prevented sex workers from making time to visit clinics for health checks and when they did many reported being treated rudely by health care providers. Women in sex work were also found to be more vulnerable to rape and in view of this fact migrant women had self-help groups to keep each other informed about abusive clients and unsafe hotels.

The participants in this study reported that health information and training often focused on one particular disease or condition and some very basic knowledge about women's bodies and how to handle common health problems were not considered as being important. Psychological health was another major area of darkness that women attempted to resolve with the help of the meager information they had. While women showed a keenness to seek both general and reproductive health care, there were certain factors that influenced their decision to visit the doctor or the clinic. The fear of arrest during transit or while being treated, the cost of treatment, inability to speak and understand the language, treatment meted out at the clinic – all had a bearing on the decision to seek medical care. In addition, there were cultural taboos that governed any discussion on reproductive health and sexual activity. Those who did not seek medical assistance for reproductive health tended to ignore symptoms until critical or self-medicated with allopathy and traditional medicines. Often help was sought from traditional birth attendants and healers with whom the women felt comfortable.

Unsafe abortions emerged as one of the key issues impacting the health of migrant women. Women in all the three sectors stated that their current occupations did not encourage pregnancy. But as abortion is illegal in Thailand, the entire activity becomes a clandestine one, putting women at great risk. The study has also shown that awareness programs on the risks of unsafe abortions and the benefits of family planning have not had much impact and women continue to take recourse to unsafe abortion procedures.

In view of the findings of this project, researchers have made some important recommendations for policy makers, health care providers and organizations that work with migrant women. Government and policy makers should provide legal status to migrants by liberalizing migration policies. There should also be a clear formulation and enforcement of labor protection policies vis-à-vis work hours, fair wages and safety measures especially in domestic work, the sex sector and home-based work. Making safe abortions available to women and providing awareness about preventive strategies to bring down unwanted pregnancies is yet another recommendation made.

Health care providers must collaborate with NGOs to respond sensitively to the health needs of migrant women. Migrant friendly policies are reflected in the use of trained translators and cultural mediators, or in the enabling of low-cost treatment etc. Organizing trainings for traditional birth attendants and health volunteers is an important service that must be rendered by NGOs providing health care. Organizations that engage with issues of migrant women can work in tandem with health care providers to address questions of exploitation and abuse which have a telling impact on the health of women. Health clinics, especially on reproductive health, and outreach campaigns should be conducted on a regular basis. Raising awareness about safe sex practices and contraceptive use is another important need identified by migrant women. Enabling self-help health groups is a means of making women understand basic health issues. Such organizations should also be able to facilitate sharing of information between trained doctors and traditional birth attendants in order to complement each other's knowledge and expertise.

A striking feature of this study has been the agency that women have shown in bringing about change in their lives – whether it is the decision to migrate, choosing the health care option that suits them best, the use of contraceptives, the formation of self-help groups, or their future plans. All these are indicative of migrant women attempting to take control of their lives in a context that is heavily loaded against them and hence concrete assistance and support is required from various agencies for them to lead a healthy and dignified life that is free of fear and abuse.

PREFACE

Women, Mobility and Reproductive Health materialized out of the research project *The Assessment of the Circumstances of Mobility and Reproductive Health Needs among Women Migrant Workers in Thailand*. This is part of the European Commission supported assessment *Operational Researches in STI and Related Services for Women in High Risk Situations in Cambodia and Thailand.* The assessment was designed to assist the National HIV/AIDS Control Program in both Cambodia and Thailand to implement high-quality and cost-effective interventions directed towards women at risk of reproductive health problems, including Sexually Transmitted Infections (STIs). It was carried out through three different but related research projects shared by four partners located in Southeast Asia and Europe. Two projects were completed in Cambodia and one in Thailand. The Municipal Health Service (Amsterdam) provided technical assistance to the researchers in both Southeast Asian countries.

The first project in Cambodia, a continuation of previous research by the National HIV Program and the Institute of Tropical Medicine (Belgium), examined a pilot STI management protocol for sex workers in Cambodia. The second, conducted by the Center for Advanced Studies (Cambodia), documented aspects and determinants of mobility and reproductive health among sex workers in Cambodia.

This report documents the findings of the research project in Thailand carried out by the Global Alliance Against Traffic in Women (GAATW), which has been, since its inception, an anti-trafficking organization that advocates for the rights of women migrant workers, particularly those working in informal economic sectors, such as the ones focused on in this report. This is a central aspect of our understanding of the anti-trafficking framework, and leads us to advocate for an increase in scope and implementation of migrants' rights in the migrating process, in their country of origin and in the destination country.[1]

[1] For a more detailed analysis of how restrictive migration policies lead to unnecessary risks during the migrating process, see: Pearson, Elaine & GAATW. *Human Rights and Trafficking in Persons: A Handbook.* GAATW. Bangkok. 2001.

See also: Wijers, M. & Lap-Chew, Lin. *Trafficking in Women: Forced Labour and Slavery-like Practices in Marriage, Domestic Labour and Prostitution*. Foundation Against Trafficking in Women (STV), Utrecht, 1997.

The rationale for doing this study is not grounded in research alone. Framing the rationale is a firm and active commitment to advocate for the human rights of migrant and trafficked women on the domestic and international fronts. The research is premised on the idea that reproductive and occupational health rights are human rights.[2] The aim of this research is to provide a campaigning and advocacy tool that can be used on a variety of grassroots and global platforms. Although some research has been done on the health concerns of migrant groups in Southeast Asia, the crucial health needs and significant patterns of health problems of such populations remain largely unrecognized. Additionally, there is a disturbing lack of appropriate responses from government bodies. Consequently, this project complements its research goals with *political objectives* that include assistance and advocacy in the following areas: safe and easy access to health care options for migrant women, particularly reproductive health care; implementation of fair migrant and labor protection policies, with guidelines on safe working and living conditions; educational outreach programs for migrants on health and body systems; and rights/entitlements in their country of residence. GAATW also aims to assist members of the target populations by providing outlets for health training, coordinating national-level discussions on the needs of their community and recommending solutions to community-experienced problems.

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[2] As described in human rights documents, such as the Programme of Action of the International Conference on Population and Development, Convention on the Elimination of All Forms of Discrimination Against Women, and International Convention on the Protection of the Rights of All Migrant Workers and the Members of Their Families.

CHAPTER 1

Research Study – Issues, Design and Methodology

1.1 Introduction

Women, Mobility and Reproductive Health is a study of mobility patterns and health trends prevalent among women migrant workers in Thailand, with specific reference to the experiences of domestic workers, factory workers and sex workers from Laos, Burma and Cambodia. The study comprehensively documents their patterns of geographical and occupational mobility, and examines trends in their awareness and perceptions of health and body systems, health care access and treatment methods, particularly in relation to reproductive health. Reproductive health in our discussions with participants had a broad description, encompassing issues pertaining to safe sex, pregnancy, family planning resources used by women, their vulnerability to and experience of sexually transmitted infections (STI) and HIV (which may or may not be sexually transmitted). In addition, sexual health support and the general psychological well-being of the women were also considered to be equally significant dimensions of reproductive health.[3]

Objectives

The overarching objectives of this study are to:

1. Analyze and assess the trends and patterns among women migrant domestic workers, factory workers and sex workers in relation to
    a. geographical and occupational mobility;
    b. awareness and perceptions of health and body systems;
    c. health care access and treatment methods, with particular emphasis on reproductive health care.
2. Advise Thailand's National HIV/AIDS Control Program of these mobility and health patterns in order to improve the efficacy of interventions and outreach campaigns.

[3] As stated in the Programme of Action of the International Conference on Population and Development: Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases.

1.2 Project Timeline

Phase One:

- Consultations with experts and NGOs regarding key issues and research format; establishment and meetings with the study's National Steering Committee (NSC) (June 2002 onwards)
- Literature survey (November 2002 – April 2003)
- Site selection process, including meetings with experts and informants on-site
- Recruitment and training of researchers (April 2003)
- Preparation of qualitative checklist, trial testing in the field and final review by NSC (March – April 2003)
- Qualitative data collection, monitoring and analysis (May – October 2003)

Phase Two:

- Consultations with experts and NGOs regarding findings from qualitative research (October 2003 onwards)
- Preparation of quantitative survey methods, including trial testing in the field (November –December 2003)
- Quantitative data collection and monitoring (December – March 2004)
- Quantitative data analysis (April – May 2004)
- Secondary literature review (June 2004)
- Report writing and further analysis of qualitative and quantitative data (February 2004 – September 2004)
- Follow-up activities and meetings, including Self-Help Health Training in Mae Sot (September 2004 onwards)

1.3 Research and Project Teams

Research Team

The research team for the study consisted of:

Project Coordinator – Jiraporn Saetang who designed the research instruments and was the principal liaison with on-site experts and partners. She recruited and trained researchers, managed and monitored the research process,[4] coordinated consultation meetings, organized and managed follow-up activities, including the Self-Help Health Training.

[4] The Project Coordinator was heavily involved with the research process in both the phases. In Phase I, she acted as supervisor to the researchers and helped them enact their field plans. She visited each site and supported them in their initial tasks. Two weeks later, she returned to evaluate the information gathered, which included a general picture of the area, the number of women available for interview, where the researchers planned to access them and possible obstacles and solutions. There was the consistent need to address how the interview participants were responding to sensitive subject material. After this initial period, the Project Coordinator continued to make monthly visits to each site. In the areas where NGOs were involved most heavily (the Central and Eastern sites), these visits were combined with meetings with the research team and members of the NGO partner for the first two months. Reports on each interview were sent to the GAATW office between these visits for feedback and review. During Phase II, the Project Coordinator continued her work with the researchers, expanding the sites to reach the goals in survey numbers. She also provided condensed trainings for new research assistants who worked on a short-term basis.

Project Manager – Bandana Pattanaik designed research instruments, oversaw the research process, and coordinated with partners and relevant agencies. She also provided supervision in the analysis and writing of the final report.

Project Consultant – Phelps Feeley assisted with the analysis of the qualitative and quantitative data, organized follow-up activities and consultations, and served as the principal writer of the report.

Researchers – Research pairs consisted of one Thai speaking researcher and one researcher fluent in both Thai and the language of the target population. Each pair worked together at a site area and collaborated with on-site contacts, participants, employers, NGO partners, local health workers and officials.

During Phase I, the team working with Burmese participants was Kanchana Dee-oot and Prada Ngochonthanchay. Working with Cambodian participants were Boonsanong Tangyudee and Supansa Sanitsonom. Sriwannapha Laosiriwanthanakut, Kingkaw Khongsompong and Sokunthea Vann worked with Lao participants. Dee-oot, Ngochonthanchay and Laosiriwanthanakut stayed on to complete Phase II with the support of the research assistants.

Project Team

GAATW prioritized the role and assistance of outside influences available to the study. These included local and national NGOs working with the target populations, such as sex workers' rights groups, migrant assistance groups and public health organizations. Contributions from government organizations and other experts working with migrants on health issues, health service providers and traditional medicine practitioners were also important to this study.

The National Steering Committee (NSC) provided guidance on aspects of research and reporting, and ensured that project recommendations had support within national and international political forums. Members of the NSC included: Dr Amporn Meesuk, National Human Rights Commissioner (Thailand); Prof. Pensri Phichaisanith, Director of the Women's Health Advocacy Foundation; Supatra Nakhapew, Director of the Center for AIDS Rights; Usa Lerdsrisantad, Coordinator of Foundation for Women; Jackie Pollock, Director MAP Foundation; Chuen

Techamahachai, Director of the Bureau of Health Promotion; and Pinyo Verasuksawas, Coordinator of the Raks-Thai Foundation.

Research Consultants – Dr Tida Violante served as the primary consultant during the write-up process, offering valuable guidance in data analysis and presentation. Dr Violante is an expert in public health matters in Thailand and the Greater Mekong Subregion.

Jackie Pollock served as a consultant through both phases of the study. As a member of the NSC, she assisted with training researchers and also served as migration expert during the analysis and write-up stages of the project.

Health Consultants – Sabala and Kranti are health activists and educators. Besides assisting in training researchers, creation of interview checklists and surveys, and data analysis, they explained the significance and implications of qualitative findings on issues of public health. They also facilitated the Self-Help Health Training and provided health knowledge and support throughout the project.

Technical Consultants – The Municipal Health Services (Amsterdam) assisted in the creation of the quantitative survey instrument, coding of procedures and the SPSS analysis of the quantitative data.

1.4 NGO Partners

The research team worked closely with non-governmental organizations that were already active in the research sites. This afforded a double advantage – first, working in collaboration with organizations already familiar with the area and population characteristics helped the team in accessing and understanding the community; and secondly, enacting and maintaining follow-up activities were facilitated through organizations committed to engagement in those areas.
Our NGO partners included:

- World Vision, a development organization conducting assistance programs and engaged with HIV/AIDS and trafficking issues among Burmese populations in the Mae Sot area.
- Center for AIDS Rights, an HIV/AIDS-related organization based in Bangkok, involved in HIV-prevention activities (outreach and education programs, condom distribution and drop-in center) among local and migrant fishing community. It also offers health care

assistance to migrant workers, including outreach programs and services for Cambodian migrant workers in Rayong.

- RaksThai foundation is committed to promoting the rights and the health and well-being of workers and migrants. Their Samut Prakan office offers services to migrant workers from Cambodia, Lao and Burma.
- Yellow Rose, a health and outreach program, works with both migrants and Thais along the Lao-Thai border in the Ubon Ratchathani province in Northeast Thailand.

Consultation Meetings with NGOs

In addition to collaborating with on-site NGOs, the research team also sought expertise from other relevant on-site and nationally-active NGOs. This process happened through a sharing meeting with NGOs working in the Mae Sot area during Phase II. Additionally, consultation meetings with nationally-active NGOs were held in Bangkok during Phase I and at the completion of Phase II. In Mae Sot, the research team met representatives from the Mae Tao Clinic, Mae Sot Hospital, Médecins Sans Frontières (MSF), World Vision, Burmese Medical Association (BMA), Shan Action for Women (SAW), Mae Ramath Hospital and Young-Chi Ou. Themes and recommendations from these meetings are factored into later chapters. The first Bangkok consultation was instrumental in forming the research plan, establishing links with related organizations and selecting the National Steering Committee members.

1.5 Data Collection Methods

For conducting the research, both qualitative and quantitative data collection processes were used. In Phase I, the researchers conducted in-depth interviews and focus groups, while quantitative surveys were carried out in Phase II.

Interviews

In order to gather a full picture of the mobility and health patterns of participants, interviews were conducted with 120 participants during Phase I. Researchers received training on the use of a detailed checklist of discussion topics meant to guide the interviews. The conceptual frame of the checklist was designed by the Project Manager and the Coordinator and developed further with assistance from members of the project team. Modifications and adjustments were made on the basis of feedback offered by the test participants following a field test.

Surveys

In Phase II, a quantitative survey was conducted with over 900 participants. Domestic and factory workers were each asked 41 questions by researchers, while sex workers were asked 55.

Additional questions were asked of sex workers to ascertain a more detailed account of reproductive health behaviors and factors for assisting future health training initiatives. Authoring of the surveys was a collaborative effort of the research and the project team members. In the final stage of Phase I, a coordination meeting of members of the project team[5] was held for review and feedback regarding qualitative research findings that would, in turn, determine survey topics for the quantitative study. A pilot study was conducted with 15 women in the Northern research site of Mae Sot. After finalization, the Project Coordinator translated the surveys into Thai and then into the working languages being used, and also checked them for uniformity. She maintained quality control of the quantitative data through supervision of survey procedures. Further monitoring was accomplished by reviewing daily diaries of the researchers.

Focus Groups and Informal Conversations

Complementing the interviews were focus groups and conversations with participants, traditional healers and local business people. Three focus groups were organized during Phase I of the project, while informal conversations with key informants continued throughout both phases. These occurred in Mae Sot and Rayong.

In Mae Sot, a group of six traditional birth attendants (TBAs) was organized for discussions on how women establish contact with them, and what the main methods of birth control and abortion trends were in the communities they worked in. Their recommendations regarding reproductive health care services were also discussed.

Also in Mae Sot, a focus group with seven sex workers was organized. Although scheduled to discuss experiences of accessing health care, the participants directed the discussion to focus on solutions to abusive situations with clients. The research team considered this equally revealing and important to their understanding of health issues.

During Phase II, a less structured discussion group was organized with four domestic workers in Mae Sot, where participants were invited to share perceptions about their occupation, details of working conditions and motivations for migrating.

[5] This included members of the Municipal Health Service (Amsterdam), Institute of Tropical Medicine (Belgium), health experts, the Project Coordinator and the Manager.

In Rayong, a focus group with six factory workers was organized to discuss indicators and symptoms of reproductive health problems, including a wide prevalence of irregular vaginal discharge reported by participants. This group was co-facilitated by the Health Consultants, and direct assistance was offered to participants through health explanations.

During Phase I, local taxi drivers in Rayong proved to be a helpful source of information on neighborhood happenings. Informal conversations with drivers were arranged on a regular basis.

1.6 Data Analysis

Interviews: All interviews were conducted in the preferred language of the participants – Lao, Burmese or Khmer. The research team decided that interviews would not be recorded on tape, as this would adversely affect participant comfort-levels. Many interview topics are considered highly sensitive subjects. The researchers took notes during the interview process and recorded the interviews (in Thai) immediately after. The Project Coordinator reviewed all interviews for completeness and quality, and summarized them in English. Summaries were then tabulated on the basis of particular subjects, with assistance from the health consultants. Later, over half of the interviews were fully translated into English for writing the report by the Project Consultant.

Surveys: Numerically coded questions were processed using the SPSS analysis with the assistance of the technical partners. The responses for the few open questions were recorded in the working language at the time of surveying and then translated into Thai and recorded each evening after the collection of the data. These responses were translated into English before being entered into tabulation programs.

1.7 Research Sites and Target Populations

The target population comprised female migrant workers from Laos, Burma and Cambodia, who were living or working in Thailand. Categories of work included sex work, factory work and domestic work. National groups and research sites were determined by the prevalence of migrant groups in Thailand and existing potential for change in terms of legal treatment and protection. Within Thailand, migrant policies for workers from Laos, Burma, and Cambodia are more developed than for other groups and, as a consequence, more likely to be influenced by advocacy

campaigns and research projects.[6] The criteria for the age of the participants were based on 'reproductive age' (15 through 44 years), rather than adult, adolescent or girl divisions.[7]

The ideal for equal distribution of participants across occupational sectors was altered (50% sex workers, 25% domestic workers and 25% factory workers) to allow for the greater diversity in experiences and health risks that sex workers reported. In Phase I, the goal was to interview 20 sex workers, 10 factory workers and 10 domestic workers from each national group. In Phase II, the goal was to survey 200 sex workers, 100 factory workers and 100 domestic workers from each national group. Due to political happenings (see: Limitations – Current Events) and a lack of access to sex workers within Lao and Cambodian migrant groups, the qualitative sample was expanded to include 23 Thai sex workers who had migrated from northeastern provinces to Central Thailand and were working in the sites used to interview Lao and Cambodian participants. In the quantitative phase, we were forced to decrease our ideal number of participants from 1,200 to 956, with the greatest numbers missing in Lao sex worker and factory worker groups.

Recruitment

Recruitment of participants occurred through three overlapping processes. The first process involved working collaboratively with NGOs and service providing institutions in the research site areas. These affiliations served as important access routes to community members and locations. These initial contacts created a web-like effect, as individual participants would introduce researchers to other members of their community. In this way, social networks served as our second process of recruitment. However, these methods alone were not sufficient to produce the sample. In all three sites, access to participants required the researchers to form working relationships with employers and managers through regular discussions and visits. In some situations, these contacts also introduced researchers to new participants, which served as a third recruitment process.

[6] Data from 1999 showed that in Thailand, there were 1,106,000 Burmese, 10,593 Cambodian and 1,261 Lao migrants. These are, by far, the largest migrant groups in Thailand. Asian Migrant Centre & Migrant Forum in Asia. Asian Migrant Yearbook 2001. Asian Migrant Centre Ltd, Hong Kong, 2002. In 2004, 1,210,633 migrants registered. Within that group 45% were female, 70% were Burmese, 15% were Lao and 14% were Cambodian. Source: UNIAP Thai News Digest, 11 August 2004.

[7] See: "Reproductive Age" in International Planned Parenthood Federation's Glossary of Sexual and Reproductive Health Terms. Online at: http://glossary.ippf.org/GlossaryBrowser.aspx

Small remunerations were given to survey participants, usually in the form of a toiletry gift, such as talcum powder or soap. The cost of these gifts was 15 baht or sixty cents. Similar gifts were offered to members of the focus groups. Condom packets were offered to sex workers and employers throughout the phases of the study.

Site Selection

Research sites were chosen in view of their sizable migrant populations and the involvement of NGOs working in the areas on related issues (see: NGO Partners). Before the data collection process began, the Project Coordinator visited each site to gain a clearer understanding of the situation and to meet local NGOs, community members and service providers. Original research sites in both phases of the project were expanded to include the Bangkok Immigration Detention Center (IDC).

Research sites are described below in correlation with the target population. Migration paths and occupational conditions are also traced briefly. Locations where national groups are present overlap geographically, and have been noted in the sections below.

Areas Used To Reach Lao Migrants:

Central Thailand: Samut Prakan, Bangkok and Chonburi

Northeast Thailand: Ubon Ratchathani Province, including Chong Mek and Khong Jiam

Both Samut Prakan and Bangkok are major destination sites for migrants from Burma, Cambodia and Laos. Samut Prakan, a small province bordering Bangkok's southeastern areas, sits on the opening of the Chao Phraya River. It has been a center for industrial activity, with over 4,000 factories noted in 1999.[8] Many migrants in the area, particularly the Burmese, work in fishery-related industries, but this study did not focus on them. Bangkok, Thailand's capital, is a highly urban center with many industries that include service, entertainment and manufacturing. As a result, it is also a major destination for migrants. These locations overlap both geographically and in terms of migrant populations. Lao workers in each of the three sectors, as well as the Cambodian sex workers were accessed at these sites.

[8] Promboon, Panitchpakdi, Pinyo Veerasuksawat, Daw May May Pyone, Nay Myo Zaw and Ko Nyi Nyi Lwin. "Myanmar Migrant Workers in Samut Sakorn – Samut Prakan" in *Migrant Workers and HIV/AIDS Vulnerability Study Thailand*. CARE Thailand/Raks Thai Foundation, Bangkok, September 1999. *22.*

Ubon Ratchathani is a mid-sized province in northeast Thailand, bordering Laos for about 300 kilometers and Cambodia for about 60 km. The small towns of Khong Jiam and Chong Mek are located east of the provincial capital, directly in the border areas shared with Laos. Khong Jiam sits on a peninsula between two rivers, which hosts numerous small-scale fishermen known for their use of traditional fishing traps. Chong Mek has an official border crossing station, the only one in the province (crossing occurs at other places unofficially as well). Chong Mek's duty free market, filled with goods from neighboring China, Vietnam and Laos, is a minor tourist destination for local visitors. At the border, Lao tourists and workers are allowed to cross into Thailand for a minimal fee, but their travel is restricted to the surrounding area.[9]

Like the Thais in this area, many Lao migrants have been caught up in the rural to urban migration patterns. This flow has been characterized by the shift from agriculture-based to a manufacture-based export economy in Thailand, which began in the 1980s.[10] Primary motivations for Lao migration have been reported to be economic in a broad sense. The continuum includes, on the one hand, the loss of farm-based subsistence due to changing markets, and, on the other, the desire of young Lao migrants for a higher standard of living that includes luxury items and entertainment. Lao migrants are directed into specific sectors: domestic work, construction, fishery-related work, agriculture and manufacturing. Women migrants tend to be involved in domestic work, but are also involved in small-scale home industry. It is common for Lao men to take on jobs that are season-dependant (fishing, construction, agriculture), though this pattern is not observed among women migrants.[11]

In this study, Lao participants tended to migrate at a young age and in groups. They crossed the border with either family members or friends who had often migrated before, or with the assistance of a migration agent. For most participants, crossing the border was relatively easy at Chong Mek, though they were only safe in town until the evening curfew at 6:00pm. After this

[9] "Lao P.D.R. Country Report" in *Migration Needs, Issues and Responses in the Greater Mekong Subregion: A Resource Book.* Asian Migrant Centre and Mekong Migration Network, Hong Kong, December 2002. *113-140*.

[10] Curran, Sara R, Fiiz Garip, Chang Y. Chung, and Kanchana Tangchonlatip. "Genered Migrant Social Capital: Evidence from Thailand." Center for Migration and Development Working Paper #03-12. Office of Population Research, Princeton University: Princeton NJ, 2003.

[11] Chantvanich, Supang. *Culture of Peace and Migration. Integrating Migration Education into Secondary School Social Science Curriculum in Thailand*, Chulalongkorn University, Bangkok, UNESCO PROAP, 2000.

time, they risked arrest for being caught on the Thai side of the street, but they were generally safe inside a home or building. This only applied to participants who remained in the border areas. In contrast, many other participants made the risky journey from these border areas to the urban centers of Central Thailand. This journey was often made in hidden compartments on buses, though in some cases participants were able to pass as Thai and ride normally in a bus or a mini van. The mandatory checkpoints on roads leading away from the border areas are the biggest danger during this journey. Lao migrants risk arrest and deportation if caught without proof of registration as a documented foreign worker or a Thai identity card.

Previous research has noted the ease with which Lao migrants are able to blend into Thai society.[12] This trend significantly increased the difficulty of the researchers in gaining access to Lao migrant workers. The Lao sex workers who could be accessed lived and worked mainly in the border market or on the Laos border with their employer (owner of a karaoke bar). Some, however, were living in Bangkok. In the border market and nearby towns of Chong Mek and Khong Jiam, the karaoke bars are generally the establishments where sex workers work and commercial sex services are locally known to be available though not openly advertised. Additionally, their services were often sought after normal working hours, in bars at different locations. The occurrence of brothels converting into karaoke bars, by placing karaoke machines inside and serving drinks, has been on the increase since the late 1990s, when government-run abolitionist campaigns tried to eradicate sex work and sex workers from many areas in Thailand. At the time of Phase II, most karaoke bars on the Thai side were closed in response to the no-

[12] "Thai culture is quite similar to that of Laotians, as both sides of the Mekong River have historically belonged to the same ethnic group. Many villagers who cross the national border are simply following historical tradition…. Moreover, most Laotians can understand and speak Thai. A survey conducted by the Institute for Cultural Research (ICR) in Vientiane in 1997-1998 found that 91% of respondents understood Thai." Trafficking in Women and Children in the Lao PDR: Initial Observations. Ministry of Labour and Social Welfare (MLSW)/UNIAP, Vientiane. October 2001. As referenced in: "Lao P.D.R. Country Report" in *Migration Needs, Issues and Responses in the Greater Mekong Subregion: A Resource Book.* Asian Migrant Centre and Mekong Migration Network, Hong Kong, December 2002. *113-140*.

Elsewhere it has also been reported: "Although the Thai and Lao languages are similar, they are not the same. Historically it would seem that with the regular interchange and flow of people to both sides of the border there would be many people on the Thai side who can speak Lao. However, it seems that the ability to speak Lao among Thai people in Chiang Khong [a border area on the Thai side] is not that pervasive…. The Lao people who come across the border for commerce or to visit relatives from Laos can usually speak some Thai and are able to read some Thai as well. Overall, however, it seems that the language barrier is permeable due to the similarity of Thai and Lao, and people can communicate generally." Press, Brahm, Sopida Suwannasopit and Ketsanee Chantrakul. "Lao-Thai Border at Chiang Khong" in *Migrant Workers and HIV/AIDS Vulnerability Study Thailand*. CARE Thailand/Raks Thai Foundation, Bangkok, September 1999. *103*.

brothel policy. Many women and the karaoke owners moved to Laos to re-open small establishments. Notably, work conditions remain the same. Women receive Thai clients who cross the border for their services and often these clients are able to take them across the Thai border.

Lao factory workers who participated in this study all live and work in Bangkok and Samut Prakan. Some of them had been recently arrested and were being kept at the Bangkok Immigration Detention Center (IDC; see below for IDC site description). In the central areas, they work in small-scale home industries that process food to be sold in nearby markets or to restaurants. In case of relatively positive working conditions, workers in this sector tend to stay with their employers for longer periods. Those registered as foreign workers are almost all under the title of domestic workers. But the actual Lao domestic workers who participated in this study live and work in either the central areas or in Ubon Ratchathani (Chong Mek and Khong Jiam districts). Although most of their work is centered on household tasks within the home of their employer, participants also reported having small responsibilities outside the home, such as helping employers with their businesses.

Areas Used To Reach Burmese Migrants:

Northwest Thailand: Tak Province, particularly Mae Sot and surrounding areas

The Tak Province, situated in the northwest of Thailand, borders Burma. It is dotted with forests and mountains. Mae Sot, the official border crossing for the province, is midway up the provincial border shared with Burma and is a major epicenter for Burmese migrant activity. In the outlying western areas of Mae Sot flows the Moei River, which acts as a natural divide between Mae Sot and Mywaddy, the Burmese town on the other side. The Thai-Myanmar Friendship Bridge on the river has small immigration booths on each side. Large bustling but dusty marketplaces shoulder the Thai side of the bridge, with Burmese trades-persons selling their goods (packaged food, cigarettes, wooden statues and other handicrafts). Down the road from the immigration office is another mainstay of migrant activity, the Mae Tao Clinic. Run by Dr Cynthia Maung, a Burmese doctor who settled in Thailand after a wave of government unrest in 1988,[13] the clinic assists Burmese migrants in the area for reduced fees and in the migrants'

[13] "Mae Sot: Little Burma." The Irrawaddy, On-line Edition. 1 May 1999. http://www.irrawaddy.org/aviewer.asp?a=1303

languages and dialects. The participants in this study repeatedly mention the services offered by the clinic.

The large population of migrants from Burma in Mae Sot is made up of diverse ethnic groups including Karen, Mon, Kayan, Burman and other hill tribe peoples.[14] While the study uses the overarching category 'Burmese', this diversity is recognized to exist within the group of participants. Primary motivations for Burmese migration include severe push factors such as forced relocation programs, forced labor programs, institutionalized sexual abuse and other human rights abuses by the current government. Economic push factors include plummeting currency rates and widely reported systems of indebtedness for agricultural laborers. Pull factors for migrants include the demand for unskilled and low-cost labor in Thailand, higher wage potential and increased political freedom, even in the tenuous position of being an illegal migrant in Thailand.[15]

Burmese migrants in this study tended to come from mixed economic backgrounds and followed the well-worn footsteps of family members or friends who had migrated before them. Often, participants had migrated within Burma, from villages and small towns to urban centers or border areas, before entering Thailand. Notably, Burmese participants did not use migration agents as frequently as participants from the Lao and Cambodian groups, perhaps because migration routes are more publicly known. Regardless of how well used these routes are, they are still considered unsafe, entailing multiple checkpoints and confrontations with officials along the way. At the Mae Sot border, the Burmese are able to cross into Thailand by paying a minimal fee for a day-

[14] See: "HIV/AIDS among Migrant Population at the Thai-Burmese Borders: Mae Sot and Mae Sai." The Asian Research Center for Migration, Institute for Asian Studies, Chulalongkorn University, Bangkok, Thailand, 2003.

See also: "Burma" in *Migration Needs, Issues and Responses in the Greater Mekong Subregion: A Resource Book.* Asian Migrant Centre and Mekong Migration Network, Hong Kong, December 2002. *21-50*.

See also: "Country Reports: Burma (Myanmar)" in *Asian Migrant Yearbook 2002-2003: Migration Facts, Analysis and Issues in 2001-2002*. Asian Migrant Centre and Migrant Forum in Asia, Hong Kong, January 2004. *92-98.*

[15] "Burma." *Ibid.*
See also: Oo, Win Kyaw. "Two Stops in the East-West Corridor" in *Invisible Borders: Reportage from Our Mekong*. Inter Press Services (IPS) Asia-Pacific, Bangkok, Thailand, 2003. *34-38.*

See also: Win, Zarny. "For Burmese Workers, Jobs are Dirty but Needed" in *Invisible Borders: Reportage from Our Mekong*. Inter Press Services (IPS) Asia-Pacific, Bangkok, Thailand, 2003. *42-46*.

pass, though they must have some documentation and their movement is restricted after the immigration offices close at 5:00 pm. They risk arrest for traveling after this time or outside of Mae Sot Township which they are generally prohibited from leaving. Most participants spoke of overstaying their day-pass and living in Mae Sot illegally at some point in their travels, or registering for work permits and living and working legally.

The town and outlying areas are populated with markets, factories and commercial sex establishments. The Burmese sex workers who participated in this study generally worked in brothels or bars, with shared rooms at the back for sleep and for servicing clients. Others worked as freelance sex workers out of hotels, bringing clients to their rooms or servicing them in other locations. Garment and other types of manufacturing industries are major destinations for Burmese migrants. These industries produce clothing, metal-ware and electronics for Thailand's local and export markets. In this sector, participants tend to live on-site in large compounds that contain warehouses for living and working. Domestic work is also a viable option for female migrants in the area and is particularly attractive for new migrants who are looking for accommodation and safety from the local police. Like their Lao counterparts, Burmese domestic workers in Mae Sot reported primarily doing typical domestic tasks including house cleaning, cooking and childcare, but also occasionally helped their employers with small businesses.

Areas Used To Reach Cambodian Migrants:

Central Thailand: Bangkok IDC, Samut Prakan

Eastern Thailand: Rayong, Khlong Yai, Aranya Prathet/Poipet and surrounding areas

The areas used to contact Cambodian migrants who worked in factories or as domestic workers included Rayong township, Khlong Yai district in Trat province, the Aranya Prathet/Poipet border and the Bangkok IDC. Although commercial sex establishments exist in all of these areas, Cambodian sex workers were accessed in Bangkok/Samut Prakan and Aranya Prathet/Poipet only. Rayong is the third province west from the Cambodian border, whereas Trat Province shares a border with Cambodia along both forested and coastal plain areas. Rayong and Khlong Yai (a small sub-district in Trat Province) are port areas where much of the local economic and migrant activity centers on fishery. Aranya Prathet is along the Thai-Cambodian border further up north, opposite to Poipet in Cambodia. There is an official border crossing between the two townships and a sizable market in Aranya Prathet where Cambodian traders can sell goods that they bring over. The numerous casinos along the Cambodian side ensure that a considerable number of Thai, Malay and Singaporean tourists frequent this border area. Although Poipet is in

Cambodia, the research team used it as an occasional access point to reach workers who had recent and significant experience working in Thailand.

It has been reported that Cambodian migrants migrate for primarily economic reasons, as the same work in Thailand pays over twice as much as it does in Cambodia. The rate of earning is still markedly less than that given to Thai workers. For women migrants, the rate is significantly low again. Within the migrant community, women generally earn less than men.[16] When migrating, Cambodians tend to use well-worn tracks, laid out and publicized by migrants who have come before them, and then settle in specific areas where migrant labor is commonly hired.[17] Cambodian migrants are hired to work in fisheries, construction sites, sawmills, farms, and in food processing industries. Fisheries hire a great number of Cambodian men[18] (and some Thai men) to do arduous boat work that requires them to be away from land for days at a time and away from their families or friends for weeks or months. Often boats only dock every several days and in different ports for the duration of a season.

Cambodian women in these areas are generally employed in fish processing factories and small-scale businesses, or as domestic workers for Thai residents around the area. Fish processing is a common vocation for women migrants who have followed their husbands in coming over the border for work and for those who are widowed or divorced. The harbor areas tend to house small-scale factories for fish processing right at the docks. In the surrounding villages and towns, women migrants are hired as domestic workers in private homes, and to a lesser extent, in small-scale businesses. Domestic workers in this area tend to work in isolation from the rest of the migrant community, with most of their work limited to the grounds and homes of their employers.

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[16] Sovannarith, So. "International Migration: some issues in Cambodia." *Cambodia Development Review* 5, issue 1. Cambodia Development Resource Institute, Phnom Penh. January-March 2001.

[17] Press, Brahm, Pinyo Veerasukawat, Panjaporn Panklin and Julthorn Sa-Art. "Cambodian Migrant Workers in Trade" in *Migrant Workers and HIV/AIDS Vulnerability Study Thailand*. CARE Thailand/Raks Thai Foundation. Bangkok. September 1999.

[18] In a study visit to Rayong, it was reported that out of 6,479 Cambodian migrants working in Rayong in 2002, 4,000 of the group were fishermen. Ministry of Health: National Center for HIV/AIDS, Dermatology and STD (Cambodia). "Report on the Second Study Tour in Thailand and the Philippines." Community Action for Preventing HIV/AIDS. September 2002.

The research team found that Cambodian sex workers tended to move further inland or stay around the crossing at Aranya Prathet/Poipet. Participants reported that this settlement trend has been necessitated by boat-worker clientele expressing preferences for Thai sex workers. Primarily Cambodian sex workers in the border areas worked in karaoke bars or brothels, which tended to be modest houses that sometimes additionally sold beer, with small rooms available for services. The buildings were often tattered and worn, but commercial sex services were more openly available at this location than in Samut Prakan, where sex workers primarily worked in karaoke bars similar to those found in the border areas but with fewer back rooms. Also, the buildings tended to be in better condition than those in the border areas. (Samut Prakan and Bangkok are described above in the section on research sites used for accessing Lao workers.)

In all the three sectors, Cambodian women were found to rely heavily on brokers and agents to cross the border, paying between 2,000-3,000 baht (USD 50-75) for the service. In general, these crossings were made in groups, with friends, family members or acquaintances and other unknown fellow migrants. For those who had connections in Thailand, or who stayed along border areas, the migration process ended at a bus or van stop across the border. At the border crossing itself, migrants do not require documentation, but are required to pay a small fee and are expected to return to Cambodia before nightfall.[19] For those without connections or who want to migrate deeper into Thailand, agents lead migrants through forested areas in order to avoid the checkpoints on the roads leading away from the border towns. It was reported by several participants that this process was unsafe for various reasons – risk of arrest, the dangers of walking through rough terrain, and the risk of being sexually abused by other migrants.

Bangkok Immigration Detention Center (IDC)

Political events of 2003 (see: Limitations – Current Events) necessitated the expansion of the research sites to include the Bangkok Immigration Detention Center (IDC) where many participants were detained. The IDC was particularly used for Lao factory workers, Cambodian domestic workers and Cambodian sex workers. Maryknoll Thailand, an NGO working at the IDC itself, provided vital information on current detainees and allowed researchers to conduct a number of quantitative surveys within the IDC.

[19] See also: Pramualratana, Anthony, Ratana Somrongthong, Kittisak Jindasak & Sakunthala Saetiow. *Assessment of the Potential for Spread and Control of HIV Among Cross-Border Populations Among the Thai-Cambodian Border*. Institute for Population and Social Research, Mahidol University, Thailand. June 1995.

The IDC has large rooms where groups of men and women awaiting deportation or other immigration proceedings can be housed, anywhere from a day to three years. Although women are moved from the initial temporary cell to a long-term cell once their case has been decided, neither space contains beds or provides privacy. The IDC provides two meals a day to detainees and is generally kept clean.

1.8 Limitations of the Study

This study hopes to avoid stereotyping and generalizations about the condition of migrants by speaking of multiple and contrasting occupational sectors and national groups. The researchers have acknowledged the specificity, diversity and differences among members of these sub-groups. Moreover, the study recognizes that a migrant group's experiences pertaining to health, work and living conditions, and mobility patterns are always in flux. Access to and responses from participants may generally hold true over a period of time, but the political climate at the time of research has a role to play in determining their responses. Additionally, research and project team members were dealing with issues that required sensitive handling. They had to be prepared to interact with strangers in unfamiliar locations, handle unexpected situations, cope with emotional trauma of migrant women – all of which would definitely have an impact on the research process. Some of these limitations are discussed below in relation to researchers, qualitative and quantitative data, and current political happenings.

Researchers

Efforts were made to create and maintain a group of researchers with parity in skills and extension of support. This was achieved through a weeklong pre-training module, and through continuous field support and regular monitoring. However, the researchers' diverse backgrounds, disparity in their levels of experience, their degree of familiarity with research skills – all had an impact on their understanding of and perspective on key ideological matters (e.g. abortion and sex work), and on their personal level of comfort while discussing reproductive health topics. Not surprisingly, this affected the quality of research data and findings to some extent.

Additionally, researchers (and the Project Coordinator) faced notable emotional and physical demands while in the field. Researchers relocated to areas where they had a few contacts since they were required to perform outreach most days during their field stay and often worked long, strenuous hours. Particular conditions necessitated these hours. For example, many factories

where participants worked allowed workers only one day off in a month; therefore, researchers needed to arrange and conduct interviews from early morning until late at night on these days. This was a precious opportunity to speak with workers for more time than what their normal one-hour breaks allowed. But constant emotional demands made on researchers during the narration of harsh and abusive conditions faced by the participants also had a significant impact on the study.

Qualitative vs. Quantitative Results

The Research Team observed notable differences in the quality and quantity of responses provided in the in-depth interviews vis-à-vis quantitative surveys. While researchers noted that most participants were initially uncomfortable and hesitant to talk about reproductive health issues (because of social taboos and cultural stigmas), qualitative interviews allowed trust and rapport between researchers and participants to be established. Unfortunately, this was not possible in the relationships between researchers and survey participants, as time was limited and relationships between researchers and participants were less developed. Responses to questions regarding STIs, sexual activity and behavior patterns, contraceptive use and abortion were significantly less detailed among quantitative participants than among qualitative participants. The Research Team feels that this was often more of a representation of the dynamics between researchers and participants than a representation of actual differences of rates between the two groups.

Additionally, in the case of reproductive health disturbances, the interviewees were asked detailed questions about signs and symptoms of reproductive health problems. Participants often described symptoms of what may have been an STI or vaginal infection, but did not consider these symptoms as indicating an infection or problem. These symptoms were noted by researchers and tabulated into categories. For the quantitative survey, participants were asked whether they knew if they had ever had an STI before, but were not asked about specific symptoms or to describe the STI. Participants in this phase may also have had reproductive health problems but did not judge them as STIs or vaginal infections. Participants may not have been able to identify indicators of infection as abnormal, as many have limited STI knowledge or may not have had an STI exam. Some of the variations in reports of reproductive health problems between groups may be attributed to these factors.

Current Events

Disparities in ease and access existed between the different research sites and occupational sectors. This unevenness was due, in large part, to the political climate of the time, specifically Thailand's policies on foreign relations, migration and sex work. In particular, four main events affected research plans and activities: 1) the conflict between Cambodia and Thailand in early 2003, 2) an emergence of a campaign to crack down on corruption and mafia activities beginning February 2003, 3) the APEC meeting in Thailand in October 2003, and 4) the coinciding of migrant registration and renewal of work permits during the same period.

In January 2003, Cambodia and Thailand were tense over comments attributed to a Thai actress. She reportedly claimed that Angkor Wat was stolen by Cambodia from Thailand. In response, mobs attacked the Thai embassy in Cambodia's capital (Phnom Penh) and over 500 Thai nationals were deported from Cambodia.[20] Thailand began a parallel campaign against Cambodians within its borders. Many Cambodian migrant workers were persecuted, arrested and deported. The Bangkok IDC reported deporting over 15,000 Cambodian workers during this time.[21] As a consequence, many potential participants in the study were either arrested or had fled the country during the time of research. Those who remained in Thailand were living in a state of fear and suspicion. This hindered the researchers from accessing and communicating with many potential Cambodian participants in Thailand.

In the following months, Thailand mounted a large-scale campaign against mafia and drug-related activities. Thirteen categories of organized crime were to be eradicated, including migration brokers and traffickers in women. Since traffic in women is often posited as synonymous with sex-trafficking, the negative attention paid to sex workers and brothels increased significantly during this time. Law enforcement officials were encouraged to make arrests, raid entertainment establishments and deport migrant sex workers. A law official working on the Thai-Lao border reported that the area police were threatened with severe punishment if a single sex entertainment business was found in their area.[22] With more than 50,000 arrests and

[20] Cheng, Tony, BBC World Service: "Quiet After the Cambodian Storm." 31 January 2003. http://news.bbc.co.uk/2/hi/asia-pacific/2711661.stm

[21] IDC records of detainees and deportations and informal/anonymous interviews with officers working there, both unpublished.

[22] Anonymous interview between researcher and police officer at Samut Prakan research site, 2003.

2,000 government 'suspects' killed in less than three months, the climate between sex workers and officials was fraught with tension and fear.[23]

Early in the fall of 2003, Thailand began preparations to host the Asia-Pacific Economic Cooperation (APEC) meeting in October. This resulted in a large 'clean-up' effort by Thai officials to sweep Bangkok free, not only of litter but also of other 'undesirables' – sex workers, beggars and migrants. Cambodian migrants were deported in planes and by normal land routes. Reports from the Bangkok IDC showed that there were over 300 arrests per day during this period, the majority of which were people from Laos, Burma and Cambodia. This was a tense and traumatic period for many migrants, migrants' rights groups and other activists. Research sites in Northeast and Central Thailand were the hardest hit by these clean up efforts, which, in turn, affected our access to target populations in these areas (particularly in the case of Lao sex workers). Efforts were made by both employers and migrant workers to hide illegal activity and migrant status. Researchers visited many karaoke bars that local informants reported were also commercial sex establishments but were denied access. Employers reported that their workers were not involved in sex work and refused interviews. Along the Thai-Lao border, researchers teamed up with a local health activist who took them to over 50 karaoke bars. This effort resulted in only 48 successful interviews and most of those were unevenly distributed. Migrant status and involvement in sex work was heavily denied.

Between July and September normally the Thai government requests migrant workers to register and renew their work permits. The period just before registration is historically unsafe for migrants as there is a heightened call for arrests of illegal workers. Unfortunately, as the registration months coincided with the preparations for APEC, a heavy-handed crackdown on migrants occurred throughout the country. Deportations happened immediately and arrests were widespread, culminating in a fearful social climate. Researchers found workers increasingly suspicious of our research intentions and unwilling or unable to talk for fear of being seen and arrested.

[23] BBC World Service: "Thai Drugs Toll Rises." Wednesday, 16 April 2003. http://news.bbc.co.uk/2/hi/asia-pacific/2953533.stm

1.9 Ethical Considerations

The research and project teams faced particular ethical challenges during the study. GAATW's previous research projects have often used participatory and action-based methodology. So it was strongly felt that researchers should remain active but participants should drive the process and the results should be used to improve conditions. With this inheritance, a question existed: how do we respond to the stories our informants tell us? It was decided that the Research Team would not initiate suggestions or interventions in participants' lives, but if help is asked for, efforts would be made to offer appropriate assistance. Consequently, it was imperative for researchers to be trained to give basic health (particularly reproductive health) advice and assistance. On numerous occasions, researchers assisted women in accessing health providers and to address basic health concerns. Researchers were also trained in basic counseling techniques. Several women indicated that the interviews were cathartic experiences for them, offering them a non-judgmental space to tell their stories. Where women spoke of trying to change harmful situations they were in, researchers were careful to follow-up with continued support after the interview process was over. In all cases, the woman's perspective on the conditions of her life was taken as paramount. Their responses based on their assessment of the situations that made up their lives were taken as the truth.

As a response to a slew of requests for further health information and guidance, the Research Team invited the Health Consultants to lead a three-stage Self-Help Health Training in one of the research locations. The participants in the training were drawn from the same communities as the women interviewed and surveyed, and wherever possible, the women who had participated in this study were invited to attend the training. The training aimed to provide self-help health concepts, knowledge and skills that the women could use to take care of themselves and assist neighbors unable to access information or services.

The next chapter provides a comprehensive understanding of migrant domestic workers' patterns of geographical and occupational mobility, trends in their awareness of general, occupational and reproductive health issues, and delineates patterns in their accessibility to health care services.

***

CHAPTER 2

Domestic Workers

Accessing domestic workers was a challenge in all situations, as much of their work happens in homes. But once a worker was interviewed, she often introduced the researchers to other domestic workers in the area. In a few other cases, when the worker had access to public space and independent movement, researchers made contact with the workers themselves. The Bangkok Immigration Detention Center was also used as a research site, and interviews or surveys there did not require permission from an employer.

In order to access Lao domestic workers, researchers approached workers and their employers with the assistance of local NGOs. For Burmese workers, researchers had to seek permission from the employers of live-in domestic workers during the qualitative and quantitative phases. In about half the cases of qualitative interviews, researchers were able to gain permission to interview the workers freely in the house when the employer was not around, or at the researcher's home. In the other half of the cases, researchers were able to make arrangements with workers directly. During the quantitative phase, researchers tried to avoid employers while surveying workers in their place of employment, as this would have impacted on workers' responses.

Of all the groups, researchers faced the greatest challenge in accessing Cambodian domestic workers due to the charged political climate between Cambodia and Thailand as detailed in Chapter 1 (see: Limitations of the Study – Current Events). Many Cambodian migrants were arrested during this time, while the Cambodian women who were contacted were often unwilling to disclose their country of origin or be surveyed. Normally, Cambodian domestic workers tend not to work outside the home as compared to Burmese and Lao domestic workers, who often assist their employers in their businesses. During this tense period Cambodian domestic workers were much less likely than other national groups to be found in public places. To survey Cambodian domestic workers, it was necessary to contact them within the confines of the Bangkok IDC. The Research Team was granted permission from immigration authorities and was then in communication with an NGO that worked inside the IDC. This research site allowed Cambodian participants to respond more freely to questions than other national groups. The NGO gave valuable assistance by alerting the researchers whenever there were Cambodian domestic workers brought in from Central Thailand and the Rayong area.

During the qualitative phase, researchers interviewed 30 women migrant domestic workers of Burmese, Lao and Cambodian origin. In the quantitative phase, over 300 domestic workers were surveyed, including 200 Lao and Burmese women and 103 Cambodian women.

2.1 Age, Education and Marital Status of Migrant Domestic Workers

In the qualitative phase of the interviews with domestic workers, participants from all national groups were generally under 30 years of age and had been domestic workers since the time of migration. Members of the Lao qualitative group were all under 30 years of age, with six out of ten interviewed women reporting to be between 21-29 years old. Seven were either single or widowed at the time of interview, while three were married. There was notably less literacy among domestic workers in general than among factory workers. In terms of literacy, eight Lao women reported being literate, while two reported being illiterate. Lao domestic workers had a lower literacy rate than the Lao factory workers, who all were literate. Within the Cambodian qualitative group, the number of literate domestic workers was 6 out of 10 (versus 9 out of 10 factory workers). Cambodian participants were older than members of the other national groups, with four women over 30 years of age and only one reporting to be less than 21. Seven Cambodian participants were married, two were widowed and one was divorced. This is in contrast with Burmese participants, of whom eight were single and only two were married. Burmese domestic workers were diverse in terms of ages. Half of the group was under 21, while three women were over thirty.

Table 2.1: Details of participants in qualitative phase

Research Site	Country of Origin	Age group			Marital status				Literacy	
		under 21	21-29	over 30	S	M	W	D	L	NL
North Thailand (Tak Province)	Burmese (10)	5	2	3	8	2	-	-	7	3
East and Central Thailand	Cambodian (10)	1	5	4	-	7	2	1	6	4
	Lao (10)	4	6	-	5	3	2	-	8	2
	Total (30)	10	13	7	13	12	4	1	21	9

Key:
Marital Status: S-single; M-married; W-widowed; D-divorced
Literacy: L-literate; NL-illiterate

In the quantitative phase, 100 domestic workers in each national group were surveyed. Seventy-two percent of Lao participants were under the age of 21, while 23% were between 21-29 years of age. Most Lao participants were single (80%) or were geographically separated from their husbands (6%), or were divorced or widowed (4%). Ten percent were married and living with their husbands. Almost 90% reported being literate and 24% of the group reported to have attended high school or higher levels of education.

In the Burmese group, 39% of those surveyed were less than 21 years old, while 32% were in the age-group of 21-29, and 27% were over 29 years of age. Like the Lao participants, a majority of Burmese domestic workers were either single (67%), or not living with the spouse. Eleven percent were widowed or divorced and 10% were married but separated from their husbands, leaving only 12% in the category of married and living with husband. Only ten percent of this group reported not being literate; over half of the group had gone through high school or higher levels of education. Cambodian participants were similar to Burmese in terms of age ranges, with 43% being less than 21 years old, 36% being between 21-29 years, and 21% being over 29. Notably, it was this group that had the highest rates of women being married but geographically separated from their husbands (20%), as well as women being divorced or widowed (37%). Thirty-one percent reported being single, while 20% were married and living with their husbands at the time of the survey. Also in this group, participants had the highest illiteracy rates (23%) and the lowest rate of high school or higher education levels (10%).

Table 2.2: Age of participants in quantitative phase

	Less than 15 years	15-17 years	18-20 years	21-29 years	More than 29 years	Total
Lao	15	29	28	24	4	100
Burma	2	16	21	32	29	100
Cambodia	2	21	21	37	22	103
Total	19	66	70	93	55	303

Table 2.3: Details of participants in quantitative phase

Nationality	Age group			Marital Status				Literacy	
	Under 21	21-29	Over 29	Single	Married w/ H	MS	W/D	NL	L
Lao (100)	72	24	4	80	10	6	4	14	86
Burmese (100)	39	32	29	67	12	10	11	10	90

Cambodian (103)	44	37	22	31	15	20	37	23	80
Total 303	155	93	55	178	37	36	52	47	256

Key:
Marital Status: S-single; Married w/H-married and living with husband; MS-married but geographically separated from husband; W/D-widowed/divorced
Literacy: L-literate; NL-illiterate

The ability to speak, negotiate, or read in Thai was an important factor in the lives of all participants. As with factory workers and sex workers, Lao domestic workers had the highest percentage of participants with Thai language skills. Sixty-three percent reported having basic Thai communication skills and 23% reported being fluent or at reading level in Thai. Fourteen percent reported having no Thai language skills. In contrast, Burmese and Cambodian participants both had considerably fewer participants who could read Thai. Although 60% of the Burmese domestic workers surveyed reported having basic Thai language skills, only 11% reported being fluent or at reading level in Thai and 29% reported having none. Thirty-six percent of Cambodian domestic workers reported basic Thai language skills, while 19% reported fluency. Cambodians were also the national group with the highest number of participants without any language ability (45% of Cambodian domestic workers). Notably, a relationship was found between having some Thai language skills and the way workers judged their employers' treatment of them. Among those who had basic or fluent Thai language skills, 59% reported that their employer treated them favorably, while 62% of those who did not have any Thai language skills felt the contrary.

Table 2.4: Ability to communicate in local language

	Able to understand and speak in basic Thai	Fluency in or reading level of Thai	Unable to understand and speak Thai	Total
Lao	63	23	14	100
Burmese	60	11	29	100
Cambodian	37	20	46	103
Total	160	54	89	303

Also, age appears to be related to perceptions of favorable treatment by an employer. Among those under 21 years, 75% reported their employer treated them kindly, 62% between 21-29 years also reported favorable treatment. The country of origin too is a factor in the kind of treatment participants received from their employers. Ninety-five percent of Lao, 71% of Burmese and 49% of Cambodian participants reported their employer treated them kindly.

2.2 Mobility History

To begin with, geographical mobility patterns will be explored in this section by examining similarities and contrasts in the spatial movement histories of participants. Next, the topic of returning to the country of origin will be discussed in brief. Finally, occupational mobility will be considered through an investigation of participants' occupational histories.

2.2.1 Geographical Mobility Patterns

Lao Domestic Workers

> *Ked's family members are farmers and they have their own farmland. Every year, they produce enough to feed the family but there is no produce left to sell. As there is still no electricity in their village, they have to depend on lamps. Ked wanted to help her mother, so her mother could have some money to spend. She had also seen Thailand on television and wanted to see what it was really like.*
>
> Lao domestic worker, 17 years old

Lao domestic workers in the qualitative phase had almost all migrated before they turned twenty (9 out of 10 cases). In three interviews, women discussed the image they had of Thailand, as an enticing place, full of opportunity and greater chances to make a profitable income. These images came not only from media sources (e.g. television and movies), but also from Lao acquaintances

who had returned from Thailand with sizable savings. Not surprisingly, women also discussed following the footsteps of their friends or neighbors in the migration process. Half of the group had migrated with a family member, while three had crossed the border with the assistance of a broker. Two other women migrated by themselves and reported they paid four times higher the normal fare for a tiny hidden seat at the rear of the bus to avoid being checked at the border checkpoint. Most of those who crossed with brokers took small vans or cars on the long back-road journey from the border to Central Thailand. In this group, women tended to pay their brokers around 2,500 baht (USD 62.50) for their services. Although the interviews were done in Central Thailand, half of the group reported crossing at one of the border crossings in Ubon Ratchathani Province, where there are fewer restrictions. They then took cars, vans or buses from the border to Bangkok. Half of the qualitative group was working in Thailand legally, having registered and received a work permit. This was notably different from the quantitative Lao group, in which only 4% had work permits. In the quantitative group, over half of the women (59%) had been living in Thailand for a month to a year, while 22% had been in Thailand for less than a month and 19% for more than a year. Most of the Lao quantitative group reported not having worked in Laos or in other places besides the one they were in at that point of time. But most of the 5% that did report doing so also reported being motivated by the chance for more money or a sense of adventure.

Burmese Domestic Workers

> *Wa-wa was thirty-nine, when she first migrated. She traveled by a two-story cargo boat. It left from a pier near her village to Mywaddy (the border town near Mae Sot on the Burmese side). The boat was very crowded and they took on as many passengers as they could. After that she traveled in a small boat across the Moei River into Thailand. She got a temporary pass at Immigration, where they asked her name, age and a ten-baht [USD .25] fee.*

> *Saleemo did not want to come to work in Thailand because she did not want to leave home and her old father. But her aunt had come to visit her village and seen that Saleemo's father was getting old. She wanted to help him by sending her niece to work in Thailand. Her aunt is an agent who brings people to work in Mae Sot regularly for a fee of 20,000 kyat per person [USD 21.62], but she covered all costs for Saleemo.*

In the Burmese qualitative group, six of the ten women interviewed had first migrated below the age of 20. Half of the group migrated with a family member, four women migrated on their own and one migrated with the help of a broker. In this case, the broker was also a family member who assisted her migrating niece to cross the border without charging her the normal agent

service fee. The general route mentioned by most of the participants in this group was to take a bus from their village or town to the border, cross the Moei River (by bridge, boat, walking, or swimming), and stop at immigration for a temporary pass into the township of Mae Sot. Some Burmese participants in the study bypassed immigration, crossing the river elsewhere. Six of the ten qualitative participants were working legally, having registered and received a work permit. In the quantitative group, only 23% reported having a work permit. In this group, most Burmese domestic workers had been living in Thailand for longer than those in the Lao group: 38% percent reported living in Thailand for more than three years, and an additional 18% between one and three years. Thirty-six percent of the group reported being in Thailand between a month to one year, while only 8% reported being in Thailand for less than one month.

Cambodian Domestic Workers

> *Na migrated to Rayong seven years ago to follow her husband who had gone there earlier but was unable to send money back home. He returned home to take Na and his brother to work in Rayong. They paid 3000 baht as broker fee. They had to walk through the jungle for a day and were then illegally transported to Rayong by a big truck.*
>
> *Cambodian domestic worker, 39 years old*

In the qualitative group of Cambodian domestic workers, 9 out of 10 participants crossed the border and were transported to their workplace with the assistance of a broker. Only one participant migrated with a family member. Those who migrated with a broker often did so in small groups, which sometimes included family members or friends. Cambodian participants reported paying either between 1,200-1,400 baht (USD 30-35) or 3,000 baht (USD 75) for the agent's services that often included placement assistance once they arrived in their destination area. Additionally, a number of women in this group discussed walking through forested areas anywhere from five hours to four days in order to avoid checkpoints in either Cambodia, Thailand or along the border itself. This process was reported to be dangerous for a number of reasons: rough terrain and a high risk of assault, particularly sexual assault by strangers in the migrating group.

Almost half of the participants (four cases) in this group reported coming from significantly disadvantaged backgrounds. They were either notably poor, without any educational training, or missing either their husband or father as an income earner. In contrast to the Burmese domestic worker group, where half were working in Thailand legally, none of the quantitative Cambodian

participants had work permits. Most of the Cambodian domestic workers surveyed in the quantitative phase had been living in Thailand for more than a year. Thirty-seven percent reported having been in Thailand for one to three years, while 25% for three years or more. Thirty-four percent reported having been in Thailand for a month to a year, while only 4% said they had been in Thailand for less than a month. Only 4% said they had lived and worked in a place other than the area they were at during the time of survey.

Table 2.5: Migration details of participants in qualitative phase

Research Site	National Group	Migrant status		Migrated with				Age at migration	
		L	IL	S	F	FM	BO	15-20	21+
North Thailand (Tak Province)	Burmese (10)	4	6	4	-	5	1	6	4
East and Central Thailand	Cambodian (10)	5	5	-	-	1	9	5	5
	Lao (10)	5	5	2	-	5	3	9	1
	Total (30)	14	16	6	-	11	13	20	10

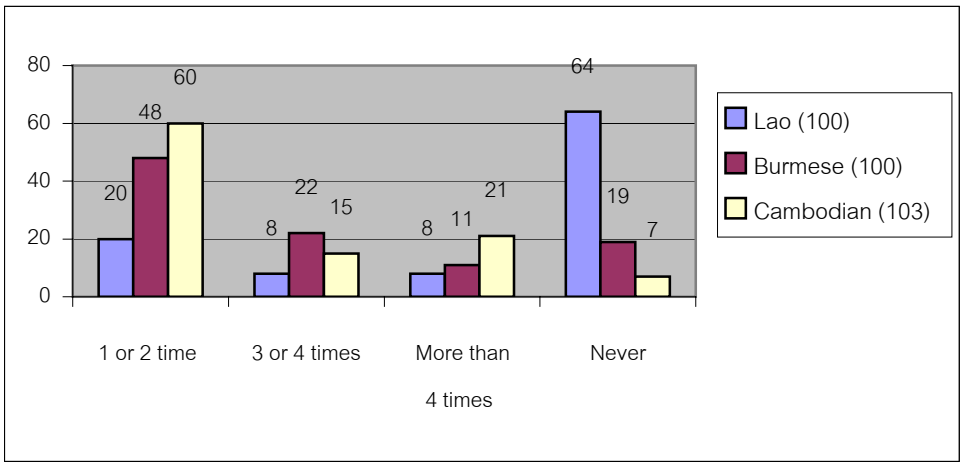
Key:
Migrant Status: L-legal; NL-illegal (without work permit or registering)
Migrated With: S-self; F-friend; FM-family member; BO-broker or agent

Returning Home

For all sectors of migrant workers, the ability to return to their country of origin was an important factor in their lives as migrant workers. Although survey participants were asked how many times they had 'returned home', the question did not specify whether home was defined as their country of origin or as the town, village or area they had lived in before. Participants could define 'home' in the way that was significant to them. Additionally, the distance from the border to the area participants are actually from or have familial ties in, can influence how often a woman returns home. If her family or village is relatively close to the border and the border is accessible to her, she may return quite often. On the other hand, if she is residing in Central Thailand or her family is quite far from the nearest border crossing, she may only seldom return. Cambodian women were the most likely to have returned home, with 70% of those surveyed having returned at least once. Forty-two percent reported having returned home once or twice, while 14% reported having returned three to four times and 13% more than four times. Among Burmese migrants, 81% of survey participants had returned home at least once, though 22% had returned three to four times and 11% had returned home more than four times. In the Lao group, 64% reported they had never returned home since migrating to Thailand. Twenty percent of Lao participants had returned once

or twice, while 16% had returned three times or more. Possibly, variability in length of stay in Thailand between national groups may relate to these different rates of return. Only 21% of Lao domestic workers had been in Thailand for over a year (versus the 56% of Burmese and 59% of Cambodian participants). As many of the Lao participants were working in the border areas, the returning rate probably does not signify trips to Laos, but refers directly to trips back to the participants' hometown or village which were usually much harder to reach than the Lao border.

Table 2.6: Frequency of returning home in the quantitative phase



There is no clear indication of whether women returned home due to the emotional bond with their family. However, in the qualitative phase, women explained the two main reasons for returning home that are possibly related to bonding. These were: medical treatment and delivery of a baby. This may also reflect their trust in the medical system and caring environments in their place of origin.

> *Tam had a prolonged problem of vaginal infection. She took a lot of medicines that she bought from a pharmacy nearby, but it was not treated completely. Later, at her mother's suggestion, she decided to make a home trip just for this treatment.*
>
> *Lao worker, 22 years old*

2.2.2 Occupational Mobility

For many new migrants, domestic work can appear like a good initial choice when they first move to a foreign country. In the qualitative phase, women reported wanting to enter domestic work because it seemed to assure them a place to live, food to eat and some sense of safety from the police. For those who had not worked before and were worried about being lonely in their new location, living or working with a family seemed like an attractive way to establish

themselves. However, once a migrant moves into domestic work, it can be hard to change occupations due to the limited number of contacts with migrants in other sectors. Compared to the qualitative groups of sex and factory workers, domestic workers moved to and from other sectors the least. Eighteen out of thirty domestic workers interviewed either had not switched jobs since migrating or had only moved from one situation of domestic work to another. Of the qualitative group, five had switched from domestic work to factory work but returned to domestic work again, while four had moved from factory work to domestic work. In the quantitative group, a quarter of the domestic workers surveyed had worked in sectors other than domestic work. In the Lao group, only 12% reported doing this. It was mainly sales work. In the Burmese group, 29% respondents said they had worked in other sectors, namely factory, sales and farm work. Cambodian participants had the largest percentage of respondents reporting that they had worked in other fields (39%). Construction and farm work were mentioned by 30%, while 28% reported having worked in sales.

Table 2.7: Occupation before current job

	Had done other kind of job before domestic work	Never did another job besides domestic work	Total
Lao	14	86	100
Burmese	29	71	100
Cambodian	39	64	103
Total	82	221	303

Domestic workers surveyed in the quantitative phase reported starting domestic work at a range of ages. The majority of Lao domestic workers reported starting domestic work before they turned twenty (21% started under 15 years of age, 37% between the ages of 15 and 17 and another 26% between the ages of 18 and 20). Sixteen percent of the Lao group and 35% of the Burmese group started domestic work over the age of 20. Among the Burmese participants, 12% started domestic work before they turned 15, while 24% started between the ages of 15 and 17, and an additional 29% started between the ages of 18 and 20. In the Cambodian group, a higher percentage started later in life – 46% began domestic work at age 20 or older. Only 3% of the Cambodian participants started domestic work before they turned 15, while 29% started between the ages of 15 and 17, and 22% between 18 and 20 years of age.

Table 2.8 Age at start of domestic work

	Less than 15 years old	15-17 years	18-20 years	More than 20 years	Total
Lao	21	37	26	16	100
Burmese	12	24	29	35	100
Cambodian	3	30	23	47	103
Total	36	91	78	98	303

When quantitative domestic worker participants were asked for the main reason for choosing domestic work, most cited economic reasons. Ninety-one percent of Burmese participants who responded cited economics as their primary reason, and likewise 80% of the Lao participants. In the Lao group, 10% also cited adventure. Among Cambodian participants, 60% cited economics as the main reason, while, alarmingly, 27% reported that an agent had lured them into this sector. Another 10% said that they had entered domestic work for adventurous reasons while 4% reported that they were forced into the work by familial pressure. The Research Team feels that 'lured by agent' in this context can refer to one or more of three different situations. In the first situation, the woman may have been given false promises or been led to have false expectations of the job and wages available to her upon migrating. In this case, an agent may have sold her services on the basis of these promises and not followed through with finding an optimal job for the migrant as pledged. In the second situation, the worker may have been tricked or misled about the cost of the agent's services and how it would affect the total sum of their wages upon arrival in Thailand. Migrant workers may find their first several months of salary greatly reduced, or used up entirely for debts incurred for using a migration agent. In the third situation, there may be the presence of slavery-like elements, where the migrant is tricked at her place of origin about where she is going, what job she will be doing and in what conditions she will be living (and paying back any debts incurred during the migration process). She may then be bought, sold or forced into particular labor situations by agents or employers, without any say in the matter.

Burmese workers, on the other hand, may have been quite well informed about what to expect from the migrating process itself and the job market available to them across the border, as the influx of Burmese migrants in Thailand is significant enough for many migrants to have a neighbor, family member or a friend migrate before them. This person often acts as an assistant or companion in the migration process and serves to emotionally prepare the new migrant about the realities of the situation in Thailand.

Table 2.9: Main reason for doing domestic work

Nationality	Economic reason	Forced by family members	Lured by agent/relative or friends	Other reason e.g. job available at that time, adventure
Lao 100	82	0	2	16
Burmese 100	91	0	0	9
Cambodian 101	60	4	26	11
Total	233	4	28	36

* 2 responses missing in the Cambodian group

> *Tin-Tin does household chores, such as cleaning, cooking, washing and ironing. She also helps in preparing food for her employer's restaurant. She looks after her employer's daughter too. She wakes up at 5:00 am, washes vegetables, slices beef and prepares food. Then she makes breakfast, takes a break to eat, and does the house cleaning and laundry after that. Around ten, she rests for a while. At noon she goes to the market, maybe visiting friends along the way. In the afternoon when the clothes are dry, she does the ironing. Sometimes during her break she prepares food, but watches television while doing so.*
>
> *Burmese domestic worker*

Conditions and Relationships

Domestic work can include a variety of tasks – house cleaning, childcare, eldercare (taking care of elderly relatives of the employers), helping employers with their businesses (in stores, restaurants and factories), washing and ironing of clothes, and cleaning employers' vehicles. The domestic workers interviewed tended to work over 12 hours a day, with some working up to 18 hours on a regular basis. Domestic workers lived either in the home where they worked or in separate accommodations, usually with family members or friends. Challenges were present in both live-in and live-out situations. For live-in workers, there was the sense that the job was never done, that the worker was always on call. For live-out workers, there was a sense of urgency in trying to finish a long list of tasks in a limited number of working hours.

Most employers were reported to provide their workers with some amount of food on a daily basis. However, a key issue determining the living conditions and the health of a domestic worker was whether she was provided with her own portion of food as well as the time to eat it, or was eating restricted to the consumption of only leftover food from their meals in her spare time. Besides the implications that it has for the nutritional content and freshness of the food, and whether the worker gets to eat regularly or goes without food for long durations, this was found to be directly suggestive of whether her services were valued and respected in her employer's home.

More than half the qualitative participants (17 out of 30 – 8 Lao, 5 Burmese and 4 Cambodian participants) were live-in domestic workers. The second most common living situation among domestic workers was reported to be living with a family member. Two out of ten Lao, four Burmese and five Cambodian participants were living with a family member at the time of the interviews.

Working hours ranged from 10 to 18 hours for the domestic workers in the quantitative phase. These hours were extendable if the worker lived in her place of employment, as her employer could call her any time of the day or night. Workers tended to work either six days a week or without a specified day off, on the understanding that if they needed to go out or do something, then the employer would allow them to do so. In the qualitative phase, the Lao migrant group worked the longest hours. Participants reported working between 15-18 hours a day, though live-ins were expected to work longer hours if their employer required it. Lao workers in the quantitative phase tended to work less hours, with 55% reporting that they worked between eight to ten hours a day and 26% reporting working ten to twelve hours a day. Another 11% reported working over 12 hours a day, while only 8% reported working less than 8 hours a day. Burmese migrants who were surveyed worked similar hours. Fifty-six percent reported working between eight to ten hours a day, while 28% reported working ten to twelve hours. Eleven percent reported working over 12 hours a day and only 5% reported working less than eight hours regularly. In the qualitative phase, Cambodian domestic workers worked an average of 13 hours a day, though this ranged from ten to sixteen hours. In the quantitative phase, these hours were notably higher than in the Burmese and Lao groups, with 81% participants reporting that they worked more than 12 hours a day on a regular basis. Eight percent reported that they worked ten to twelve hours, while another 8% reported working eight to ten hours and 5% reported working less than eight hours.

Table 2.10: Estimation of work hours per day

	Less than 8 hours	About 8-10 hours	More than 10-12 hours	More than 12 hours
Lao 100	8	55	26	11
Burmese 100	5	56	28	11
Cambodian 103	5	8	9	81
Total 303	18	119	63	103

Wage patterns were also different among national groups, with Burmese workers earning significantly less than their Lao and Cambodian counterparts. Lao workers who were interviewed earned an average of 2,640 baht per month (USD 66), though this ranged from 2,000-4,300 baht

(USD 50-107.50) per month. Similarly, Cambodian workers earned an average of 3,030 baht (USD 75.75), with incomes ranging from 1,500-4,500 baht (USD 37.50-112.5) per month. In contrast, Burmese domestic workers who were interviewed earned an average of 950 baht (USD 23.75), with a range of 500-2,000 baht (USD 12.50-50) per month. Clearly the specific characteristics of the labor markets in each of the research sites dictated particular standards of acceptable pay. In the sites used for contacting Burmese workers, the supply of Burmese migrants far outweighs the demand of local industry, both formal and informal. The town itself is quite small, rural and far from the next city. These factors are highly influential in determining wages. As a result, employers in several homes in this area have hired multiple domestic workers to do specific tasks in both their home and business. In contrast, Lao and Cambodian workers tended to work in more urban areas, where there are not as many migrant workers available. As many Cambodian workers migrated with the assistance of agents, the agent network itself proved useful in negotiating for a better standard of wages.

In addition to better monthly salaries, workers in relatively positive employment situations were offered a number of provisions that included toiletries, medical assistance, clothing, food and money for their days off. For those living in their place of work, a factor in determining satisfaction was whether they had a private room with a lockable door or whether their 'space' was always publicly accessible by their employers. Having a private room not only helped in demarcating periods when the worker was on or off duty, but also reassured her in terms of safety. A central safety issue was the risk of male employers visiting workers' rooms at night and making unwanted sexual advances.

Violence

> *Saleemo, a 16-year-old domestic worker, came from a very poor family. Her aunt who had been working in Mae Sot for many years took her from Burma to get her a job as a domestic worker. Her first job as a domestic worker wasn't a very good experience because she was harassed by her male employer. So her aunt found her another employer. But after a few months, Saleemo was raped by her new employer. He forced her to take 2 tablets after the rape. Saleemo didn't know what the medicine was. (It could have been the emergency pill to prevent pregnancy.) Her aunt came to know about this and brought her back to stay with her family in Mae Sot. While waiting for a new job, Saleemo was raped by her uncle. Her aunt blamed her for this and gave her a pill similar to the one her employer had given her and took her to a clinic for an injection. Saleemo had no idea what she was injected with. After a few days she found employment as a domestic worker.*
>
> *Burmese domestic worker, 16 years old*

For domestic workers, the risk of violence is increased by the isolated nature of their work. This isolation can prevent them from asking their peers for help or assistance in abusive or unfair situations or from being able to gauge what is normal versus what isn't in an employer-employee situation. In interviews with workers, women who worked in unfavorable situations discussed employers being verbally insulting, abusive or withholding their salaries. In extreme cases, employers were also physically or sexually abusive to the workers. In interviews with Lao workers, two participants revealed being raped, while four described situations where their wages were long overdue. In interviews with Burmese domestic workers, three women reported that their employer had confiscated their identity documents, while another three were not given their salaries for a long time. In addition, there were notably higher accounts of physical or sexual harassment, and abuse or threat of abuse in the interviews with Burmese domestic workers. Three Burmese women reported being raped by their employer, one of whom was also a family member. In two other cases, participants described the physical aggression of their employer, a constant risk for the women. In the interviews with Cambodian domestic workers, reports of violence were less tied to work and more tied to their relationships with husbands or boyfriends; however, there was also a report of an employer withholding a worker's salary and one of physical/verbal abuse.

In the quantitative phase, there were fewer reports of violence experienced at the job. Researchers attribute this difference to the intimate and trusting relationships that develop between them and the participants during the qualitative interviews, quite in contrast to the brief conversations the quantitative survey required. Among Lao survey participants, three women reported being assaulted at work, with two cases being employer-related while the third was due to threats by the police. Similarly, eight Burmese participants reported having been assaulted at work; most of these cases were abuse by employers. In contrast, 23 of Cambodian participants reported that they had been assaulted at work, with a number of these reports involving rape by an employer.

Challenges and Rewards

In investigating the work conditions of domestic workers, quantitative participants were asked about their relationships with their employers and about the challenges and rewards of domestic work. In response to questions about their relationship with their employers, 93% of Lao and 72% of Burmese respondents reported that their employers treated them kindly, while 24% of Burmese and only 2% of Lao respondents reported that their employers treated them badly. This was in contrast to responses from the Cambodian participants. Half of the group responded that their

employer treated them kindly. However, 25% reported that their employer overworked them – 11% reported that their employer treated them badly in general and another 14% reported that their employers were verbally abusive (shouted at them often). The conditions in which the surveys took place could be a factor in the differences between these rates. In both the Lao and Burmese groups, researchers often had to conduct the survey in the participant's place of employment. As a consequence, there was always a threat that their employer was nearby, despite the researchers' attempts to conduct them in private spaces. An employer could overhear a critical response directly or hear from another worker or acquaintance in hearing range. Therefore, participants may have limited their critiques of their employers for fear of repercussions. In contrast, the interviews of Cambodian domestic workers were almost exclusively done at the IDC, away from employers and the threat of informants. While the IDC was not an ideal or relaxed space to conduct a survey, participants may have been more honestly critical of their previous working conditions.

Table 2.11: Treatment by employer

Nationality	Treated kindly	Treated badly	Gave more work, no rest time	Verbal insults	Sexual harassment	Total
Lao	93	2	5	0	0	100
Burmese	72	24	0	4	0	100
Cambodian	50	11	25	14	3	103
Total	215	37	30	18	3	303

The pattern of responses was similar when workers were asked about the challenges and rewards of domestic work. When asked about the worst aspect of domestic work, 85% of Lao quantitative participants responded that there was nothing bad about domestic work. Those who responded otherwise identified the worst aspects of domestic work as being isolation, bad attitude of the local police and tough work. In response to the same question, 83% of the Burmese participants reported that there was nothing bad about the work. But some respondents mentioned employer's mood swings, verbal abuse, and the isolation that the job entailed as constituting some of the worst aspects. In the Cambodian group, only 4% respondents reported that there was nothing bad about domestic work. Forty-seven percent respondents reported that their employer's violent behavior was the worst thing, though this behavior was not specified. Twenty-six percent reported that the isolation of the work was the worst thing.

Table 2.12: The worst thing about domestic work

Nationality	Violence by employer	Bad attitude from others	Isolated	Others	Nothing bad/ no worst thing in this job	Total
Lao	0	2	1	12	85	100
Burmese	0	1	3	13	83	100
Cambodian	46	27	26	0	4	103
Total	46	30	30	25	172	303

When asked about the best aspect of domestic work, national groups continued to have varied answers. Among Lao participants, 35% reported friendly employer as the best aspect, while another 35% reported their incomes and 11% reported the ease of the job as the best thing about their work. An additional 12% reported that safety at workplace was the best thing about their current employment, while 5% said there was nothing good in their job at all. In the Burmese group, 57% participants reported that having a friendly employer was the best thing, while 22% listed their incomes. Nine percent reported ease of work, and 5% safety at workplace as the best aspect of their job. Among Cambodian participants, 50% reported their income as the best thing, while 23% regarded having a friendly employer as the best part of the job. Fifteen percent Cambodian participants reported that their not-too-heavy job was the best feature, while 13% reported that a safe work environment was the best. It is notable that a significant percentage of each group reported safety at workplace as the best aspect of domestic work. This pattern highlights that safety, particularly from the risk of arrest and deportation, is a major concern.

Table 2.13: The best thing about domestic work

Nationality	Income	Friendly /kind employer	Not heavy work	Safe place to stay	Other reasons	No good thing in this job	Total
Lao	35	35	11	12	2	5	100
Burmese	22	57	9	4	0	8	100
Cambodian	51	24	15	13	0	0	103
Total	108	116	35	29	2	13	303

2.3 General, Occupational and Reproductive Health

> *Sow Sow feels she is in good health, meaning that there is nothing to worry about. She has some pain but thinks that it is because of age (46 years). "I am not a healthy young woman anymore." Her only problem now is joint pain, which sometimes causes swelling and is very painful. Sow Sow takes medicine daily to cure the pain but skips it whenever she gets swollen joints.*
>
> *Burmese domestic worker, 46 years old*

2.3.1 General Health

In addition to gathering research and responses on the actual state of health of migrant women, it was important to assess how the workers in this study perceived their own general health status and their health awareness. When the quantitative group of domestic workers was questioned about whether they thought they knew enough about their health and body systems to be able to take care of themselves, Burmese workers responded with the highest percentage of positive responses at 77%. Eight percent of Burmese respondents said that they did not know enough, while an additional 15% reported that they were not sure if they knew enough about their health and body systems to take care of themselves. When Lao participants were asked the same question, only 14% reported that they knew enough and 11% reported that they were not sure (in other words, 75% reported that they did not know enough). This was in contrast to the 8% of Burmese participants who said they did not know enough about their health and body systems. Only 3% of the Cambodian participants claimed they knew enough about their health and body systems. However, in this group, 83% reported that they were not sure whether they knew enough. Another 14% reported that they did not know enough about their health and body systems to take care of themselves.

Table 2.14: Knowledge of health and body systems for self-care

Nationality	I think I know enough to take care of my health.	No, I don't think I know enough to take care of my health.	I'm not sure.	Total
Lao	14	75	11	100
Burmese	77	8	15	100
Cambodia	3	14	86	103
Total	94	97	112	303

Answers to questions regarding the participants' assessment of their own state of health continued to vary among national groups. Lao participants had the highest rates of reports of their health being very or fairly good at 74%, while an additional 16% reported that their health was average. Only 6% of the group reported that they thought their health was rather poor or very poor. Not surprisingly, Lao participants also had the lowest percentage of reports of current health problems (33%). In the Burmese group, numbers were dramatically less – 52% reported that they thought their state of health was very or fairly good. Thirty-six percent of the respondents reported that they thought their health was average, while 4% reported their state of health as being rather poor or very poor. Numbers nearly doubled between Lao and Burmese participants when asked

whether they had any current health problems. Sixty-nine percent of Burmese respondents reported that they had a health problem. In the Cambodian group, numbers continued to follow this tendency, with 40% reporting that they had very or fairly good health and an additional 43% reporting that they thought their state of health was average. Twenty percent of the Cambodian participants reported that they thought their health was rather poor or very poor, the highest percentage among the three groups to respond this way. Notably, 78% of the group reported having a current health problem, which was also the highest percentage among the three groups.

Table 2.15: State of health

Nationality	Very/fairly good	Average	Rather poor	Don't know	Total
Lao	74	16	6	4	100
Burmese	52	36	4	8	100
Cambodia	40	43	20	0	103
Total	166	95	30	12	303

2.3.2 Occupational Health

> *Kien feels her health isn't as good as before. She usually has headaches and gets dizzy easily. Kien thinks it is because she doesn't get enough sleep due to hard and long hours of work. She has never seen a doctor but buys medicine at the drug store for her problem.*
>
> *Cambodian domestic worker*

Domestic workers face a number of health risks in their occupational tasks. In the qualitative interviews, women reported high rates of stress-related headaches, back and body pains due to lifting weight and other hard labor (watering plants, moving and carrying things, helping in their employer's shop), and skin infections or allergies from working with detergents and strong cleansers throughout the day. As noted before, domestic workers are often expected to work long hours that can lead to sleep deprivation and a general feeling of exhaustion, weakness and, in several cases, dizziness. Among quantitative participants, there was a notable relationship between an increase in the rates of existing health problems and an increase in time spent working over eight hours a day. While 50% of those who worked between 8-10 hours a day reported having health problems, 60% reported the same out of the group that worked 10-12 hours a day. The number sharply increased when workers were expected to work more than 12 hours a day, resulting in 74% reporting that they were having health problems currently. This was particularly

true among Burmese participants who worked more than 12 hours a day, as 88% of that group reported having health problems.

Table 2.16: Work hours related to current health problems in quantitative phase

Working hours	Yes, I have a health problem currently.	No, I don't have any health problem.	I'm not sure whether I have a problem.	Total
Working less than 8 hours/day	9	5	2	18
Working 8-10 hours/day	60	57	2	119
Working more than 10-12 hours/day	35	24	4	63
Working more than 12 hours/day	74	27	4	103
Total	178	113	12	303

Digestion troubles were quite common among interviewed domestic workers and may be linked to substandard nutritional intake and inconsistent eating patterns. When employers only allow their workers to eat leftover food and/or eat only at times when they are not busy with other tasks, workers may end up eating insufficient amounts of food that is decomposing, eating irregularly or skipping meals altogether. Additionally, several participants described having to hold their urine for long periods while working. When combined with a tendency not to drink enough water, this may lead to or aggravate urinary tract infections (UTI).[24]

Among Lao participants in the qualitative phase, digestion trouble was the most commonly mentioned health problem. Four out of ten interviewed participants reported having either diarrhea or constipation, while another three reported heartburn and indigestion. There is a cultural preference for heavily spiced food among Lao participants, which may explain some of these cases. The limited and often unhealthy diet may be part of the reason 3 out of 10 Lao domestic workers also mentioned having anemia, which results from a lack of iron and can be related to diet. Another three women reported having UTIs, and two women reported having regular headaches or dizziness. In addition to sleep deprivation, cases of dizziness may also be related to anemia. In the quantitative phase, headaches were the most commonly cited health problem by Lao participants: 30% reported having them regularly. Nine percent reported having regular back, neck or shoulder pain, while another 6% reported body or joint pain.

[24] UTIs, however, could also be related to reproductive health problems such as vaginal infections or STIs going untreated.

In the Burmese and Cambodian groups, headaches and body pains were the most commonly mentioned health problems, although in the qualitative study 4 Burmese domestic workers mentioned UTIs. This may have been caused by holding in urine and not drinking enough water. Three participants reported having regular headaches or dizziness and another three described having feelings of general weakness on a regular basis. In the quantitative phase, responses differed. Headache was the most commonly mentioned health problem. Among Burmese survey participants, 22% reported having regular headaches, 17% reported neck, shoulder or back pain and 10% reported body or joint pain. Another 6% reported regular episodes of dizziness.

Among Cambodian qualitative participants, 7 out of 10 women reported having regular headaches or dizziness. This was the highest percentage of headaches per qualitative group. An additional four women reported having regular back pain and three discussed having UTIs. Thirty-three percent of Cambodian quantitative participants reported regular headaches, while 13% reported neck, shoulder or back pain and 9% reported body or joint pain. Notably, 8% in this group mentioned having chest pain on a regular basis. This may have been due to respiratory problems.

Table 2.17: Current general health problems in quantitative phase

Current general health problems	Lao	Burma	Cambodian	Total
Acidity/Stomachache	1	10	2	13
Back pain/Neck/Shoulder	9	17	13	39
Headache/Migraine	30	22	33	85
Sore eyes/Ear pain	1	2	4	7
Sore throat/Flu/Fever	1	1	5	7
Chest pain/Asthma/Cough	0	4	4	8
Blood pressure	1	2	0	3
Dizziness	4	6	1	11
Joint pain	4	10	7	21
Vaginal discharge	7	0	10	17
Urine burn	0	0	2	2
Low abdomen pain	1	0	4	5
Irregular menstruation	4	0	5	9
Total	63	74	90	227

2.3.3 Reproductive Health

In this section, research results from domestic workers will be compared to that of factory workers in order to determine a more detailed picture of the reproductive health of domestic workers. Contrasts and similarities will be indicated in terms of reproductive health awareness,

sexual activity rates, contraceptive use and reproductive health ailments. Determining factors resulting in notable differences will also be indicated and discussed.

Awareness

Awareness of reproductive health issues was significantly less among domestic workers than among factory workers. Again however, several qualitative participants in each national group showed an understanding of specific contraceptive methods that friends or family members had told them about. In a few cases, NGO workers had helped them to understand reproductive heath risks and possible ways to keep themselves safe, but generally domestic workers were much more isolated from NGO education campaigns than factory workers or sex workers. In the Lao group, while six out of ten women discussed knowledge of contraceptive methods, four women knew only about oral contraceptives or condoms. Furthermore, four reported that their contraceptive knowledge was due exclusively to either friends and family members or NGO programs.

In the quantitative phase, domestic workers reported receiving less health information than the factory workers. Among surveyed domestic workers, 66% reported they had never received health information, whereas 45% factory workers reported the same. This was particularly true among Burmese domestic workers, where 91% reported never having received any health-related information compared to 50% of Burmese factory workers. Sixty-eight percent of Lao participants and 39% of Cambodian participants reported that they had never received any health-related information. Cambodian women had the highest rates of having received some health information in the past, with 28% of them reporting that they had received information about contraception and safe sex, and 21% reported having received information about HIV. In the Lao group, 15% of participants reported receiving information about HIV, while 12% reported having received information about menstruation. The percentage of Burmese domestic workers receiving health information was surprisingly low compared to responses from Burmese factory workers, considering the number of health outreach programs and initiatives at the research site. However, this testifies to the isolated nature of the living and working conditions of many domestic workers in this study. Only 8% of Burmese participants reported receiving information about HIV, while 4% reported receiving information about contraception/safe sex.

Table 2.18: Receiving health information in quantitative phase

Received Health Information*	Lao (100)	Burmese (100)	Cambodian (103)	Total 303
Never received information	68	91	39	198
Cancer	1	0	5	6
Contraception/Safe Sex	5	4	28	37
STIs	5	3	7	15
HIV	15	8	21	44
Menstruation	12	2	8	22

*Participants could respond to this question with more than one answer (except where they responded 'Never received information').

Sexual Activity, Condoms and Other Contraceptive Methods

> *Sui has worked for three years as live-in domestic worker. She does not know anything about reproductive health. Although she is sexually active, she has not received any information on having safe sex or contraceptives. When she was in Burma, her mother didn't tell her anything about this. According to her, women in Burma are not supposed to talk about sex.*
>
> *Burmese Domestic Worker*

Within the quantitative group, fewer domestic workers reported sexual activity than did the factory workers. Only 19% of domestic workers said they are sexually active. Reasons for this may be the heightened isolation of domestic work and restrictions against coupling affecting live-in workers. The age ranges of participants in the group may also have been an influential factor, though generally participants in the study were sexually active under 21 years of age. Twenty-eight percent of factory workers and 58% of domestic workers were under 21 at the time of survey. Sexual activity among Lao and Burmese domestic workers was relatively equal (rate of 15%), whereas among Cambodian participants, the rate was 28% percent. This may be attributed to the higher rate of married women in the Cambodian quantitative group.

Table 2.19: Sexually active in past 6 months in quantitative phase

Nationality	Yes	No	Total
Lao	15	85	100
Burmese	15	85	100
Cambodia	28	75	103
Total	58 (19 %)	247 (81%)	303

Oral contraceptives were, by far, the most popularly used method of contraception in both the qualitative and quantitative domestic worker groups. In both the Lao and Burmese qualitative groups, three out of ten women reported using oral contraceptives. Seven out of ten Cambodian women reported using them. Again, this may be due to an increased number of sexually active participants. For Lao and Burmese domestic workers, two out of ten reported having used condoms. One participant in each national group reported using injectible contraceptives. Cambodian participants did not report any other type of contraceptive use. During interviews, Cambodian participants explicitly discussed not using condoms because of the trust they had in their husbands or partners. Other interview participants discussed their partner's refusal to wear condoms and a feeling of taboo or shyness about bringing up these sensitive issues when the participant knew that there was a risk of STI transmission.

> *Wee's husband is working on a fishing boat and lives with her at the site. Wee never asks her husband to use a condom because she believes that her husband never visits sex workers. She uses oral contraceptive to prevent pregnancy.*
>
> *Cambodian domestic worker, 33 years old*

> *Korn knows about using condoms from her friend who came to work in Bangkok. When the friend came home to visit, she told Korn that people in Thailand prevent pregnancy by using condoms. After working in Bangkok, she learned more about using condoms from television programs.*
>
> *Lao domestic worker, 22 years old*

Table 2.20: Use of contraceptive method to prevent pregnancy in qualitative phase

Nationality	Oral pill	IUD	Depo-injection	Condom	Other, implant	No
Lao (15)	8	1	1	2	1	2
Burmese (18)	7	0	2	0	3	6
Cambodian (28)	9	4	9	0	2	4
Total 61	24	5	12	2	6	12

Condom use among qualitative participants was very low, and oral contraceptives continued to be the most popular contraceptive option. When participants were asked for their main method of preventing pregnancy, answers varied. Among the 15 Lao participants who reported sexual activity, 8 of them reported using oral contraceptives and 2 reported using condoms. Only one Lao participant reported other methods, including IUDs and injectible contraceptives. Seven of the Burmese participants who reported using contraception cited oral contraceptives as their main method of preventing pregnancy, while two used both injectible and implanted contraceptives. In

the Cambodian group, 9 women reported using the oral contraceptive method, 4 reported using the IUD and 9 the Depo-injection.

> *Pia knew about oral contraceptives because her aunt had told her about it. She started using them after her marriage and has been using them for about six months. The pills cost her 35 baht [USD .87 per month]. Pia uses the pill because she is not ready to have a baby yet. She wants to have time to make money for a secure future. Pia's husband agrees with her because both of them are still too young to have a baby.*
>
> *Cambodian domestic worker, 25 years old*

Reproductive Health Problems

The Research Team noted that most domestic workers, particularly the Lao group where 80% were single, were initially uncomfortable and hesitant to talk about reproductive health issues. This may have been due to their marital status. But once trust was established between researchers and qualitative participants, several women readily talked about their reproductive health problems. This was not possible with the quantitative survey participants as time was limited. Responses regarding reproductive health disturbances and infections were significantly less among quantitative participants than among qualitative participants. The Research Team believes that this is more a representation of the dynamics between researchers and participants than a representation of actual differences of rates between the two groups.

Table 2.21: Reproductive health problems in qualitative phase

Ailment	Burmese	Cambodian	Lao	Total
Menstrual Disturbances	3	2	6	11
Vaginal Infections/ PID	6	6	8	20

Eleven out of the thirty qualitative participants reported pain during menstruation, heavy or irregular bleeding, absence of menstruation, severe cramps or the passing of large blood clots. These were all categorized as menstrual disturbances. Additionally, 20 out of 30 women reported having excessive, discolored or foul smelling discharge, vaginal pain and severe itching in the vaginal region. These symptoms fell into the category of vaginal infections or Pelvic Inflammatory Diseases (PIDs).

Table 2.22: Reporting STI in quantitative phase

Nationality	I have had STI.	No, I have never had infection.	Don't know.	Total
Lao	1	75	24	100
Burmese	0	95	5	100
Cambodia	9	59	35	103
Total	10	229	64	303

Obviously, researchers were not able to get the same types of details from quantitative participants. Those who were surveyed were asked whether they knew if they had ever had STI before, but were not asked about specific symptoms or to describe the STI. Consequently, there might have been under- or mis-classification of STIs. Participants in the qualitative phase often described symptoms of what may have been an STI, but did not consider them as indicators of a type of disturbance. Likewise, participants in the quantitative phase may also have had reproductive health problems but did not judge them as STIs. Almost exclusively, 95% Burmese participants reported not having had an STI, while Lao and Cambodian participants were less unified in their responses. In the Lao group, 75% reported not having an STI before, while 24% reported that they did not know if they have had one or not. Similarly, 57% of Cambodian participants reported that they have never had an STI before, while 34% reported that they did not know. It was only among the Cambodian participants that a significant percentage of participants (9%) reported having had an STI before. Again, however, the absence of STIs reported or known about does not necessarily mean that there was an absence of menstrual disturbances or vaginal infections. Participants may not have been able to identify infection indicators as abnormal, may not have had an STI exam or may have possessed limited reproductive health knowledge.

While participants were not asked what their HIV status was, they were asked if they had had their blood tested for HIV and whether they knew the results. In the Burmese group, 17 women reported being tested, with 11 women knowing the results. In the Cambodian group, 15 women reported having had their blood tested for HIV, and 13 women were aware of the results. Similarly, out of the 12 Lao participants who had their blood tested, 10 of them reported knowing what their results were.

Table 2.23: Reporting blood test for HIV infection in quantitative phase

Nationality	I have had blood test done.	No, never had it done.	Don't know.	Total
Lao	12	77	11	100
Burmese	17	74	9	100
Cambodian	15	87	1	103
Total	44	238	21	303

Table 2.24: Knowledge of HIV test results in qualitative phase

Nationality	Yes	No
Lao (12)	10	2
Burmese (17)	11	6
Cambodian (15)	13	2
Total (44)	34	10

Pregnancy, Miscarriage and Abortion

Generally, domestic workers in the qualitative phase reported being discouraged from pregnancy. Pregnancy and childrearing could reduce their work capacity. In some cases, this was strongly communicated by employers. Many made contraceptive use mandatory or clearly stated that the worker would lose her job if she decided to have a child. In other cases, it was the worker's own analysis of the spatial (if she was a live-in worker), economic and time constraints of her position that discouraged her from having a child. A few participants from this sector indicated a preference for giving birth in the country of origin with a traditional birth attendant (TBA). This was less the case, however, than reported in interviews with factory workers. In examining this difference, it is notable that half the Cambodian domestic workers, who had the highest rate of marriage and children, lived with family members. This meant that they could keep their children with them while another person in the community looked after them during the day. In the case of Lao workers, as many of them were young and unmarried, going home in case of pregnancy was not an available option due to the stigma associated with single motherhood.

In the qualitative interviews, accounts of miscarriages and abortions were discussed. There were three cases of miscarriages reported by domestic workers during interviews. Two of these cases attributed their miscarriages to hard physical labor. As domestic workers often lift heavy weights

and carry out physically challenging tasks, miscarriage appears to be an occupational risk.[25] Complications from unsafe abortion procedures were also discussed in the interviews. Ten out of thirty women recounted stories of side effects and difficulties related to abortion procedures. In no case did the abortion take place in a hospital, or in safe conditions that met basic medical standards or under the supervision of a doctor.

> *Wa Wa is 46 years old. She has had three children and five pregnancies. Wa Wa found out about STIs after she'd had two or three children already. She learned about different risks of diseases through talking with other soldiers' wives, but did not learn many details about the diseases themselves. Although she isn't comfortable talking about STIs with her husband, she brought up the topic of contraception in the context of preventing further pregnancies. They agreed to use the withdrawal method but it didn't work. Because she already had three children and money was a consideration, she decided on an abortion herself. An acquaintance told her of a place where she could get the abortion done. She didn't consult anyone or tell her husband because she was afraid he would not let her. Also, her mother would not agree for an abortion. For the abortion, the doctor inserted cotton wool dipped in medicine into her uterus and left it there for two days, after which blood began to come out. Before blood started oozing out, she had bad stomach pains. But Wa Wa doesn't think that she has had any major health problems as a consequence.*

Cases of pregnancies were most frequent in both the qualitative and quantitative groups of Cambodian domestic workers. As this group also had the fewest single participants, this was not surprising. In the qualitative interviews, five Cambodian participants discussed having abortion complications, while one woman reported miscarriage. In the quantitative section, 60 Cambodian women reported being pregnant at least once, while 20 out of 26 Burmese participants reported giving birth. Only 2 reported miscarriage and abortions, while 8 women reported stillbirths. Lao participants had the lowest pregnancy rates. While all the ten women had given birth once, two reported a miscarriage and none reported having an abortion.

Table 2.25: Reporting Pregnancy in quantitative phase

Nationality	Yes	No	Had live birth/s
Lao (100)	10	90	10
Burmese (100)	26	74	20
Cambodian(103)	60	43	59
Total 303	96	207	89

[25] "The Effect of Workplace Hazards on Female Reproductive Health." National Institute for Occupational Safety and Health, Ohio, 1998. http://www.cdc.gov/niosh/pdfs/99-104.pdf

Table 2.26: Reporting miscarriage and abortion in quantitative phase

Nationality/number	Miscarriage	Abortion	Still birth, ectopic
Lao (10)	2	0	2
Burmese (26)	2	2	8
Cambodian (60)	0	12	0
Total 96	4	14	10

2.3.4 Psychological Well-Being

In order to gain a more comprehensive picture of their health, women were asked about their mental and emotional well-being. Generally speaking, the isolated working conditions were a notable determinant creating stress for the participants. Domestic workers, who often live separately from other migrants from their country of origin, miss out on typical community-based social and cultural support systems. For many participants, these factors can lead to feelings of alienation, loneliness and depression. During interviews, some women also discussed being triggered into bouts of loneliness on observing the family life of their employers. This was particularly so for women who had left their children behind in their home country in order to work in Thailand. The fact that domestic work is much less formalized than factory work adds to their feeling of insecurity and uncertainty. Because of the informality of domestic work, employer praise and blame tends to be taken personally and thus found to be much more immediate and influential on the state of mind. Participants also spoke about the need to be 'on alert' psychologically when they were around their employers. It was also important for many women to gain cultural and social acceptance into the families they were working for, as they were the main source of social interaction for the workers. All these factors amplified for workers who lived in their place of employment.

Table 2.27: Mental health problems in quantitative phase

Nationality	Yes	No	Total
Lao	10	90	100
Burmese	26	74	100
Cambodian	60	43	103
Total	**96**	**207**	**303**

Lao participants had the lowest rates of mental and emotional health symptoms in both the qualitative and quantitative phases. Their ability to communicate in the local language (86%) could be a reason for this. In the qualitative phase, four out of ten participants reported feeling a

heightened sense of fear at the thought of police arrest or abuse. Loneliness, restlessness and loss of appetite were other conditions reported by the Lao group. In terms of coping activities, two participants spoke of locking themselves in a room. This may be an indication of the necessity for some private time or space away from their employers. Another participant mentioned crying as a coping mechanism, and two women discussed having attempted suicide in response to distress. In the quantitative group, 10% of Lao participants stated that they were currently experiencing stress, boredom and sadness. In other responses, 14% of the group reported having been depressed in their work. Coping activities were similar in all three groups. Only a few Lao participants, however, reported talking with friends (6%), doing nothing or trying to forget (5%) and talking with their employer (2%) as coping activities.

Although participants in the qualitative groups of Burmese factory workers and domestic workers had similar mental and emotional health symptoms, in the quantitative phase, domestic workers had notably higher rates of current mental and emotional health symptoms. In the qualitative group, 4 out of 10 domestic workers reported experiencing depression or sadness, 2 reported loneliness, and another 2 reported restlessness. In terms of coping activities, two women mentioned talking with friends. As with Lao domestic workers, two women in the Burmese group also discussed having attempted suicide in response to feelings of distress. In the quantitative phase, 93% of Burmese domestic workers reported having current mental or emotional health symptoms, in comparison with 71% of Burmese factory workers. Among domestic workers, 31% of the group reported feelings of sadness, 14% reported feelings of stress and 11% reported feelings of insecurity. An additional 9% reported loneliness; while in response to a different question, 35% reported that they have been depressed with their work. In terms of coping activities, when asked about the places or people participants would go to for mental help, 26% of Burmese participants explicitly said they would not go anywhere or to anyone. An additional 6% reported that they would go to their employer. When asked how they cope with depression, 37% reported crying, while 5% reported that they would try to forget it.

Cambodian participants were the most expressive about their mental and emotional well-being and discussed their coping activities. Five out of ten members of the qualitative group reported experiencing bouts of fear, mainly fear of the police, though fears of pregnancy and male employers were mentioned as well. Cases of restlessness and bouts of depression/sadness were each reported by four participants, and two participants discussed having stress-related headaches. In response to these feelings, two women described locking themselves in a room.

Alarmingly, seven of the ten women interviewed reported having attempted suicide – the highest rate of suicide attempts among both domestic and factory workers. In the quantitative group, 98% of participants reported having a current mental or emotional health symptom. Although this was the highest among domestic workers, it was similar to the percentage of Cambodian factory workers (94%) who said the same. In part, this could be attributed to a decrease in the degree of cultural taboo associated with discussing feelings of distress among Cambodians. Thirty-three percent of Cambodian domestic workers reported having experienced insecurity, while 27% reported episodes of sleeplessness and 11% reported feelings of loneliness. Twenty percent reported feelings of sadness, while 89% reported depression. This was notably higher than the 69% of Cambodian factory workers and the 43% of Burmese domestic workers who said the same. When asked how they cope with their depression at work, 55% reported crying, 25% reported talking with their employer and 7% reported trying to forget it. A small minority of 6% reported talking with their friends in order to cope. A comparison of coping strategies mentioned by Cambodian factory workers (where 27% reported talking with friends or family members) further indicates the isolation from community members many domestic workers face.

> *Ann attempted suicide once when she was working as a domestic worker. She was treated badly by her employer, who would shout, yell and was very strict all the time. She was given a lot of work and no time to rest. She fell sick often, had chronic headaches, body pains and a feeling of fear all the time. "I felt like there was no solution to even one problem I had." She took a handful of painkillers but nothing happened. She just slept for long hours and had stomach pain for a few days.*
>
> *Cambodian domestic worker, 20 years old*

2.4 <u>Access to Health Care Services</u>

Self-medicating and trying to ignore problems were the most popular responses to health issues in both the qualitative and quantitative groups. In the qualitative interviews, 6 out of 10 Lao women discussed not seeking medical treatment, even in the case of serious indicators such as chronic migraine and joint pains. Three out of ten Lao participants talked about self-medicating (particularly in response to digestion problems), while four reported having had some medical treatment in the past. Of the women who sought and received medical treatment, two were in near-critical conditions when they sought help. Another one in the same group reported using her work permit benefits to obtain treatment. In the Burmese group, there were several cases of self-medication, including three cases of traditional herbal remedies, which are often available in the markets of Mae Sot. Additionally, three out of ten women discussed buying medicines from a drug store in which a trained or a Burmese-speaking pharmacist may have worked. Four Burmese

participants reported having sought medical attention, though 3 of them were able to go to the Mae Tao Clinic, an NGO health service set up for Burmese migrants. Five out of ten of the Cambodian participants discussed having self-medicated, with three of them using traditional herbal remedies regularly brought from Cambodia by traders. All three cases where herbal remedies were used were reproductive health problems. In all these cases, women were accompanied by NGO staff, an employer, or a family member during treatment. In 9 out of 30 of the qualitative interviews, participants, especially those who were live-in workers, mentioned that their employers provided them with some painkillers.

> *Ann's current employer took her to hospital when she had a severe liver infection. She couldn't work for many days. The doctor diagnosed it as a very serious problem of liver failure. She was finally sent home with the help of the employer.*
>
> *Cambodian domestic worker, 20 years old* [26]

> *Jar had a chronic headache. Her employer often gave her medicines but she didn't know what they were. Sometimes the medicines did not work, so her employer would give her some money to buy medicines from the nearby pharmacy. She could speak with the seller in Burmese because most of the pharmacies in the town have Burmese workers.*
>
> *Burmese domestic worker, 23 years old*

Table 2.28: Addressing health problems in quantitative phase

Nationality	Saw doctor	Self-medication	Ignored it
Lao (56)	21	25	10
Burmese (56)	33	21	2
Cambodia (97)	14	43	40
Total (209)	68	89	52

In the quantitative phase, participants reported accounts of health problems in the last six months, whether they were currently taking medication regularly and reasons why they saw a doctor in the last six months. Out of the entire quantitative group, only 33% of those who reported having current health problems also reported seeing a doctor. Forty-three percent of the group reported they self-medicated and 25% reported ignoring the problem. Responses varied by national groups. When participants were asked how they addressed health complaints they had had in the last six months, 45% of Lao domestic workers reported they had self-medicated, while another 37% reported they sought a doctor's attention. Another 18% reported that they ignored their health problems. Fifty-nine percent of Burmese participants reported that they had seen a doctor

[26] Researcher's note: We met Ann while she was waiting to be sent back home by the agent in Bangkok. Her employer had paid for all the expenses.

to address health complaints; this represented the highest percentage of domestic workers who sought medical attention. Again, this may be due to the availability of health-related NGO projects serving the Burmese migrant community in the research areas. Cambodian participants had the lowest rates for having seen a doctor, at only 14%. Forty-four percent of Cambodian participants reported that they have addressed health problems by self-medicating and 41% reported that they have ignored the problem. An additional 7% reported not being sick.

Among those who did seek medical assistance from a doctor, more than 80% were addressing a general health problem, such as a flu, fever or body pains. In both the Lao and Cambodian groups, 18% of those who saw a doctor in the last six months reported seeing one for reproductive health problems. However, this dropped to 12% among Burmese participants. Cases of self-medicating were more common than seeing doctors. In terms of medications, 38% of Lao participants and 43% of Burmese participants reported that they were taking a medication or drug regularly. Almost all of those participants reported taking paracetamol, and 8% of Lao participants reported using antibiotics. In the Cambodian group, the percentage of those taking medication or a drug regularly jumped to 83%, with most of the people using paracetamol. This could be related to the high reports of current health problems in the group (at 78%), many of them being headaches, back pain and joint pain.

In addition to questions about health services that participants did or didn't have access to, quantitative participants were also asked about the kind of health information they would like to receive. Among Lao participants, 79% reported that they required information concerning menstruation, breast and cervical cancer, HIV, STIs and safe sex. Among Cambodian participants, 84% reported needing information on HIV, STIs, safe sex, contraceptives, and breast and cervical cancer. About 20% in each group reported that they did not need any health information.

Table 2.29: Health information willing to receive

What kind of information would you need?	Lao	Burmese	Cambodian
HIV/STI/Safer Sex	19	30	46
Cancer	25	40	13
Contraception	1	4	16
Menstruation	24	4	11
Other	5	1	0
Don't want information	21	21	17

2.5 Future Plans

The future is generally uncertain for many migrants. The risk of arrest or deportation and returning to the country of origin for personal reasons are factors leading to indecision or ambiguity. When participants did have future plans, the Research Team generally felt they were exhibiting striking levels of self-determination and confidence. In the case of domestic workers, when asked what work they planned to do in the future, only one participant out of 303 reported that she would like to continue doing domestic work. Even those who had no plans or were unsure about their plans did not want to stay in this work sector for an extended period (more than five years).

When asked specifically how long they planned to stay in their current occupation, the highest percentage reporting that they did not have a plan were Lao participants (62%). Four percent of Lao participants reported that they planned to stay in their current place of employment for six to 12 months. Similarly, 58% of Cambodian participants also said they had no plans, though 37% reported that they planned to stay for longer than a year in their current place of employment. In contrast, only 10% of Burmese participants reported that they had no plans, and nearly an equal percentage reported that they planned to stay either 6 to 12 months (26%) or more than a year (27%).

Table 2.30: Plan to stay in current employment

Nationality	Less than 6 months	6-12 months	More than 12 months	Don't know / no plan
Lao (100)	32	4	2	62
Burmese (100)	37	26	27	10
Cambodia (103)	3	5	37	58
Total 303	72	35	66	130

Table 2.31: Future plans

What is your future plan?	Lao 100	Burmese 100	Cambodian 103
Have or work on a farm or rice field	28	30	13
Have a shop here	9	39	16
Another job here	3	11	2
Live with children family/boyfriend at home	1	4	9
Study/training at home	3	1	1
Sales girl at home	1	15	4
Get married at home	1	0	0
No plan / don't know what to do yet	54	33	53*

* Five Cambodian responses are missing.

When questioned about what kind of work they planned to do in future, more than 50% Cambodian and Lao participants reported that they had no future work plan or were unsure what to do; 33% Burmese participants reported the same. The majority of Burmese participants reported that they would like to continue working in Thailand. Participants reported that they wanted to open a shop (39%) or planned to do other kinds of work in Thailand (11%). This is considerable in terms of examining the desirability of staying in Thailand among migrants. For Burmese migrants, this desire may be amplified by the political situation in Burma today. Among Lao participants, 28% reported that they wanted to go into rice farming, while 9% reported that they planned to open a shop in Thailand. Sixteen percent of Cambodian participants preferred to open a shop or take up a different job in Thailand, while 9% wanted to go back to their country of origin and live with their families.

2.6 Conclusion

Domestic work can appear like a good first choice for work when moving to a foreign country. Women, especially those who had not worked before, reported wanting to enter into domestic work because it seemed to assure them of a place to live, food to eat, and some sense of safety from the police. However, once a migrant moves into domestic work, it can be hard to change occupations due to the limited number of contacts with migrants working in other sectors. Compared to the other groups, domestic workers moved the least to other lines of work.

Domestic workers get isolated from other migrants due to the nature of their work. This isolation prevents them from being able to ask their peers for help or assistance in abusive or unfair situations or from being able to understand the norm in an employer-employee situation. Those who worked in unfavorable situations discussed employers being verbally abusive and withholding their salaries. In extreme cases, employers were also physically or sexually abusive. The isolation of domestic workers was a determinant factor in creating stress. Domestic workers, who often live separately from other migrants from their country of origin, miss out on typical community-based social and cultural support systems. For many participants, this led to feelings of alienation, loneliness and depression. As domestic work is much less formalized than factory work, a feeling of insecurity and uncertainty was prevalent among several workers.

Awareness of reproductive health issues was significantly less among domestic workers. Generally, domestic workers are much more isolated from NGO education campaigns than

factory or sex workers. A staggering 66% of domestic workers in the quantitative phase reported *never* having received health-related information in the past, particularly Burmese domestic workers (91%). Domestic workers face a number of health risks in their occupational tasks. In the qualitative interviews, women reported high rates of stress-related headaches, back and body pains due to lifting heavy things and other hard labor, as well as skin infections or allergies from working with detergents and strong cleansers throughout the day. Digestion problems were quite common among interviewed domestic workers and may be linked to substandard nutritional intake and inconsistent eating patterns. Additionally, several participants described having to hold their urine for long durations of time while working. This could be attributed to the incidence of urinary tract infections (UTI) among many participants.

As for reproductive health problems, almost 50% of the workers in the qualitative phase reported having irregular menstruation, absence of menstruation, severe cramps or passing of large blood clots. The findings also point out misunderstandings around the issues of safe sex and contraceptive use. Self-medication and ignoring problems were the most popular responses to health problems. Medication was sought only when problems became serious and there were no signs of improvement.

The current situation of migrant domestic workers as reported in the research reflects a need to regulate domestic work to ensure workers are protected under domestic labor laws covering working conditions and health care services. The alarming link between long working hours and the state of well-being should prompt immediate intervention from the state agencies (labor and health) to prevent further hazards to the lives of domestic workers. Special programs have to be initiated both by government and non-government organizations to disseminate information relevant to the needs of domestic workers and to bring them out of the isolated conditions in which they work. Reproductive health care, including safe sex education, should be provided in their own language since most of the domestic workers are in their reproductive age.

Attention has to be paid to the regulation of the recruiting mechanism, as an alarming 27% of Cambodian workers reported that an agent had lured them into the sector. It is necessary to develop a system through which women can seek help when they find themselves in vulnerable situations. It is equally crucial to take awareness-raising initiatives both in the home and host countries to facilitate safe migration.

***

CHAPTER 3
Factory Workers

During the qualitative phase (Phase I) of the study, 30 migrant factory workers of Burmese, Lao and Cambodian origin were interviewed. In the quantitative phase (Phase II), the target group was expanded to include 228 factory workers – 100 Burmese and Cambodian each and 28 Lao. Although the original goal was to survey 100 members of each group, researchers were unable to reach the additional 72 Lao factory workers due to the political climate at the time of research (see: Limitations of the Study – Current Events). These events determined the research sites, as well as greatly restricted the number of Lao migrants that researchers were able to contact.

Since specific migrant groups tend to be recruited into particular types of factory work in particular areas, the research focused on different types of factories to access each national group: Lao participants in food processing, Burmese in garment factories and the Cambodian participants in fish processing factories. But this is not a rule. For example, Burmese women work in fisheries on the southwest coast of Thailand, while Cambodian women in food processing factories in Central Thailand. This chapter will review information on the different sectors and the participants working in them. Following that, there will be an examination of the geographical and occupational mobility patterns of the participants, their work and living conditions, their health perceptions and state of health (particularly occupational and reproductive), their ideas about the levels of access they have to health services and some discussion about their future plans.

3.1 Age, Education and Marital Status of Migrant Factory Workers

3.1.1 Food Processing Factory Workers: Lao

> *Kean migrated to join her husband who was working in a food processing factory. She got a job immediately when she arrived. She receives 150 baht per day, and her working hours are 8:00 am to 3:00 pm weekdays, and 7:00 am to 11:00 am on Saturdays. She has Sunday off each week, but doesn't want to go anywhere. All workers have to bring their own lunch and dinner because the factory does not allow workers to leave during the break. Kean works in the packing section where she has to sit all day long. She often feels sleepy while working, so she eats fermented fruit (very sour and spicy) to keep herself awake. She is aware that her working conditions are not supportive, but she prefers to continue in this kind of work rather than doing another job, especially domestic work.*
>
> *Lao factory worker, 26 years old*

All of the Lao factory worker participants in the study were either involved in food processing at the time of research or directly before that. The Bangkok IDC was also utilized as a research site for both the phases as researchers were able to contact only a limited number of Lao migrants on-site due to political events mentioned earlier. Before arrest, all the women interviewed and surveyed had been involved in food processing in one way or another. Primarily, women worked in informal home industries where 5 to 20 workers lived and worked in one house. Their work included tasks such as cutting meat, pickling chillies, and making sauces as well as packing them. These packaged foods were then taken to the local market to be sold, sometimes by the same women who prepared them, though most often by someone else. Other participants worked in large restaurants doing food preparation tasks such as cutting meat or vegetables, washing produce or preparing sauces.

The ten Lao factory workers who were interviewed ranged in ages from 15 to 50, with half of the group reporting their age as 20 or even younger. Six of them were single at the time of the interview, three were married and one was divorced. Literacy rates were higher in this group than among Burmese or Cambodian participants, with all of the women interviewed reporting that they were literate. In the quantitative study, 28 women were surveyed – half of them were 20 years old or younger. Only two women were over the age of 29. This was the youngest group of factory workers surveyed. Eighteen women in this group were unmarried and 10 reported that they were married and living with their husbands. Twenty-one women reported that they'd had primary-level schooling, and four women reportedly finished high school.

As Laotian is similar to Thai, their Thai language skills were better than those of other factory worker groups, with all participants reporting that they had at least basic speaking and understanding skills. These language skills appear to help Lao migrants move around Thailand with more ease than members of other migrant groups. Additionally, these rates mirror the 90% surveyed Lao sex workers who also reported having basic Thai language skills.

3.1.2 Garment Factory Workers: Burmese

> *Papa, a 20-year-old factory worker, migrated to Mae Sot to work in a factory with the help of her aunt and a local agent whose service charge was 2,000 kyat. She was sent to a factory in Mae Sot that had around 500-600 workers. She was asked to start work immediately. Her wage was 25 baht per day and 4 baht per hour for overtime work. Everyone had to help keep the place clean. Men were not allowed to drink alcohol or smoke while working. Papa worked in the section for sewing*

raincoats. She lived in shared accommodation with small bunk beds, one person per bunk. A cardboard box for keeping clothes was used to divide each bunk from the other and belongings were stored under the bed. Those on the top bunks put their boxes of clothes at the bottom of their beds. The first time she saw the accommodation, Papa felt it was too crowded as she was used to her roomier accommodation at home. But if she was going to work there, she had no choice. There were a total of 15 bathrooms, 5 for men and 10 for women, as the factory employed more women than men. All three meals of the day were free. Breakfast was tea and a sweet cake, and lunch and dinner were rice dishes. The rice there was good but the dishes were not so good because the cook made it for a large number of people and so didn't really put a lot of effort into it. Working hours were from 08:00-17:00 and lunch from 12:00-13:00 and overtime is 17:30-22:00. They were forced to do overtime every day. Sometimes she has worked until 4 am and then started work the next day at 8:00 as usual.

Burmese factory worker, 20 years old

For qualitative interviews, researchers contacted Burmese migrants who worked in garment factories where they performed tasks such as sewing, measuring, weaving, embroidering and packing. The factories in these cases tended to be large closed compounds with big warehouses, some for working and others for living. These factories house and employ anywhere from 150 up to 2,000 workers at a single location. Garment factories in the research site were, and continue to be, a primary destination for many Burmese migrants.

Garment Factory in Tak Province

The Burmese factory workers that researchers interviewed were all over the age of 20, with seven out of ten being between 30-50 years of age. On an average, they were older than the Burmese sex workers, as this occupational sector seemed to have less demand for younger women workers. Of the ten women interviewed, six were single, three were married and one was divorced. In the qualitative phase, nearly all the women were literate (nine out of ten participants).

In the quantitative phase, 100 Burmese factory workers were surveyed. Most were between the ages of 21-29 (50%), 25% were under the age of 21 and another 25% were over 29. Similar to the qualitative participants, 46% were single, 40% were married and living with their husbands, and 14% were either geographically separated from their husbands or widowed/divorced. All Burmese factory workers were literate: 43 women had passed primary to secondary level and 57 women had completed either high school or higher level.

Researchers also asked about their Thai language skills. In the Burmese group, Thai language skills were reported to be low, with over 50% of the women reporting to have no Thai language skills whatsoever. Thirty-seven percent had basic understanding and speaking skills, while only 4% were fluent or could read Thai. The insular nature of the factory compounds and community meant there was less pressure for this group to learn Thai than among the other national groups, or compared to Burmese sex workers who have Thai clients. This does not mean, however, that their lack of Thai language skills didn't present clear obstacles in their day-to-day lives. It limited their movement and communication outside the factory, access to health care providers and also affected their negotiations with employers. But many factories in Mae Sot employ supervisors of Burmese origin selected from workers who have been working in Thailand for many years and who are thus fluent in Thai. The supervisors serve as bridges between managers and the Burmese workers. But there are many factory managers who can speak Burmese and this enables them to communicate directly with the workers.

> *Sang once had a problem with her supervisor and since then her supervisor has ignored her requests and has become very strict with her working hours. Often, she is unable to use the toilet until her lunch break at the end of the day. She cannot talk with the manager about her problems.*
>
> *Burmese factory worker, 19 years old*

3.1.3 Fish Processing Factory Workers: Cambodian

> *After she divorced her alcoholic and abusive husband, Lon left home for the first time to the Rayong province of Thailand. She lives and works with her sister, who came to Rayong a few years ago. Her work is to clean skin off squid, for which she is paid by the kilogram – 20 baht/kg. She earns about 60-100 baht a day. She works until 1:00 in the afternoon. If there isn't a lot of squid, she only works until noon. She has not been able to send money home as yet because she doesn't earn much. Her employer is good to all workers.*
>
> *Cambodian factory worker, 30 years old*

In qualitative interviews with Cambodian factory workers, researchers spoke with women who worked in fish processing factories and performed tasks such as sorting out different types of fish, cleaning, cutting, drying and shifting fish. In many cases, husbands of the interviewed women worked for the same company on fishing boats. The fish processing factories are not as formally structured as the garment factories where the Burmese women worked. The 'factory' itself tended to be an open room or space on a port where fishing boats could dock and bring up their catch. Although employers did not provide living accommodation, many owned houses nearby and rented them to the workers. All the Cambodian factory workers in the qualitative phase were over the age of 20, with six out of ten under 30. Seven were married and there was one participant in each category of single, widowed and divorced. Most women were literate, with only one woman reporting to be illiterate. This was similar to the high rate of literacy within the qualitative group of Cambodian sex workers.

In the quantitative phase of the study, all the 100 Cambodian factory workers were active in fishery-related work. Similar to the qualitative group, 50% of the women were between the ages of 21 and 29, though 25% were above 29, and 25% were below 21 years of age. The marital status of the workers in this group was similar to those in the qualitative interview, with 40% of the group reporting they were married and living with their husbands. Twenty percent of the group reported being either widowed or divorced, and 10% were single.

The level of Thai language skills was higher among Cambodian factory workers than among their Burmese counterparts, with 46% having basic speaking and understanding skills and 15% reporting to be at a fluent level. These factories were less isolated than the ones in the Burmese research site, with increased freedom of movement and contact with local populations. The higher rate of language skills in this group may be attributed to this increased interaction with Thais. In spite of this, 39% women reported having no Thai language skills at all.

Table 3.1: Details of participants in qualitative phase

Research Site	Nationality	Age group			Marital status				Literacy	
		15-20	21- 29	30-50	S	M	W	D	L	NL
North Thailand (Tak Province)	Burmese (10)	-	3	7	6	3	-	1	9	1
East and Central Thailand	Cambodian (10)	-	6	4	1	7	1	1	9	1
	Lao (10)	5	3	2	6	3	-	1	10	-
	Total (30)	5	12	13	14	13	1	2	28	2

Table 3.2: Details of participants in quantitative phase

Nationality	Age group			Marital Status				Literacy	
	Under 21	21-29	Over 29	Single	Married w/H	MS	W/D	NL	L
Lao (28)	16	10	2	16	12	0	0	3	25
Burmese (100)	25	50	25	46	40	10	4	0	100
Cambodian (100)	24	44	32	10	64	6	20	37	63

Key: Marital Status: S-single; Married w/H-married and living with husband; MS-married but geographically separated from husband; W/D-widowed/divorced; **Literacy**: L-literate; NL-illiterate

Table 3.3: Education level of participants in quantitative phase

Nationality	Primary to secondary	High school-higher	Never gone to school	Total
Lao	21 75%	4 14%	3 11%	28
Burmese	43 43%	57 57%	0 0%	100
Cambodian	59 59%	4 4%	37 37%	100
Total	123 53%	65 28%	40 17%	228 100%

Table 3.4: Ability to communicate in local language in quantitative phase

Nationality	Basic Thai	Fluent Thai	No Thai	Total
Lao	28 100%	0 0%	0 0%	28
Burmese	38 38%	4 4%	58 58%	100
Cambodian	46 46%	15 15%	39 39%	100
Total	112 49%	19 8%	97 42%	228

3.2 Mobility History

3.2.1 Geographical Mobility Patterns

The migration routes and patterns of the factory workers did not vary too dramatically from those among other sector participants. In many cases, factory workers knew a considerable amount about the work that awaited them, since family or community members had done the same before.

> *Nang decided to migrate when she was advised that she would get a good job in Thailand. Her advisor also suggested she enter Thailand through the border at Loungnumthar province of Lao. She and her friends crossed the border into the Mukdakhan province of Thailand and took a public bus to Bangkok. She paid the driver an extra 600 baht to provide a hidden seat. At the Bangkok bus station, they took a taxi straight to Samut Prakan where her sister was working.*
>
> *Lao factory worker, 17 years old*

Among Lao migrants in the qualitative study, women tended to migrate in groups, with family members, friends or a migration agent. Almost all the women in this group migrated at an early age (90% moved before the age of 20), with the intention to help support their families at home. Most of the Lao factory workers interviewed crossed the border using public bus routes, paying an extra fee to the drivers so that they could sit hidden under the bus. This is a common way of crossing borders and many bus drivers take the risk of smuggling migrants to make some extra money. In general, it was reported that the police do not inspect this location for extra passengers when buses go through checkpoints. This way of crossing is moderately comfortable; women reported having a fan, electricity and food in the section underneath. In the quantitative study, research sites were expanded and included locations that did not require such covert border crossings. In Chong Mek and Khong Jiam, Lao migrants were able to cross back and forth freely during the day. Seventy-one percent of the Lao quantitative participants and 7 out of 10 qualitative Lao participants were working in Thailand without work permits or registration.

> *During her journey from Burma, Mew-Mew felt uneasy being away from her parents. Also, traveling with only women and no men, she was afraid the agent would try and deceive them as she had heard that many Burmese girls were tricked into the sex trade. So she asked the agent directly and was told that they were not going to be tricked and that they would be taken straight to the factory. The agent arranged a day-pass for her and brought her straight to the factory.*
>
> *Burmese factory worker, 20 years old*

Among Burmese factory workers of the qualitative study, 8 out of 10 migrated at twenty. Nine out of ten migrated with friends or family members, often following the footsteps of mothers, fathers, sisters or brothers who had migrated before them. Similar to the participants in the

Burmese sex worker group, several women reported coming from well-off families. Four interviewed participants reported moving to the capital city, Rangoon, before heading into Thailand. Women reported entering Thailand by crossing over the Thai-Myanmar Friendship Bridge, and either paying the fee for a day-pass at immigration or bypassing immigration entirely. Nine out of ten qualitative participants and 90% of the quantitative Burmese participants had work permits and were registered as documented migrant workers.

> *Thoun decided to work in Thailand because her sisters told her that the work there was easy and that she could earn a lot of money. A neighbor had also just returned from Thailand with a lot of money. Her parents let her and her older brother and sister go. She took a bus to Phnom Penh and traveled from there to the border with an agent, and then met another one who continued the journey with them for two days, walking through mountains and wilderness. They took a truck with 30-40 people from that point to Rayong. Her sister knew the agent who had brought them to the border and was the one who paid the agent 4,500 baht (USD 112.50) per person for assisting members of her family.*
>
> *Cambodian factory worker, 40 years old*

Among Cambodian factory workers in the qualitative study, 5 out of 10 women interviewed reported that they had migrated with a family member, while four reported crossing the border with a migration agent. Those who had an agent paid an average 2,000 baht (USD 50) for their assistance in crossing the border. For an additional fee, some agents also helped in finding jobs for the migrant women once they had been brought into Thailand. Some women experienced or witnessed sexual harassment and violence en route to Thailand. But none of them took action against the brokers as they were isolated and feared for their security.

> *A Cambodian broker brought me from home to work here. There were altogether 25 women in the group. I didn't know any of them. We all had to stay in a small hut in a forest for three days. One of the women was raped in the hut and another man wanted to rape me while I was sleeping. Both of us could not do anything. We were alone and nobody cared to help. Everyone just wanted to get out of the forest and get jobs.*
>
> *Cambodian factory worker, 21 years old*

Several women were divorced at the time of the decision to migrate (though many of them had remarried by the time these interviews were conducted) and wondered how they were going to support themselves without a husband, particularly those who had children. Researchers also heard cases of women migrating in order to re-establish contact with their husbands who had previously migrated but had not kept in touch.

After I had a child, my husband migrated to Thailand. In the first three years after he left, he never contacted his family. A relative of mine told me that he had got a minor wife. I couldn't do anything. Later, he started sending money back home, about 2,000-3,000 baht (USD 50-75) each time. Sometimes he sent 8,000 baht (USD 200). I didn't care much about the money but I always prayed for his safety. I decided to migrate because I had lost touch with him and because a relative of mine has worked here for many years.

Cambodian factory worker

At the age of migration, members of this group were considerably older than members of the other factory worker groups. Eight reported they were 21 years old or older when they came to Thailand. Six out of ten interviewed women had work permits and were registered as documented migrant workers, while only 36% of the quantitative participants reported the same.

Table 3.5: Migration status in quantitative phase

Nationality	Have work permit	No work permit
Lao (28)	6 21%	22 79%
Burmese (100)	90 90%	10 10%
Cambodian (100)	36 36%	64 64%
Total (228)	132 58%	96 42%

In general, the study found migrant factory workers to be less geographically mobile than migrant sex workers. However, many workers demonstrated occupational mobility, switching between factories when jobs opened up. Movement was largely dependent on where wages or treatment was reported to be better, or if they had close connections with workers in those factories. Although only 6% of women surveyed responded that they had worked in another region of Thailand or a country besides Thailand (not including their country of origin), 5% said that they had done so because they wanted to make more money or for better working conditions. Bangkok was the commonly cited location where they had worked.

Returning Home

When Sati returned home, she didn't recognize her grown-up child. Mother and daughter started crying after they recognized each other. But back home, Sati wasn't happy because she was used to working in Thailand and earning money. At home, she had no income and only expenses. After a month, she returned to work in

Thailand. She went back to Mae Sot, leaving with 10,000 kyat (USD 10.81).[27] *She found work in another factory through Burmese contacts in Mae Sot.*

Burmese factory worker, 24 years old

Among all sectors of migrant workers, the ability to return to their country of origin was an important factor in deciding whether to migrate. Although survey participants were asked how many times they had returned home, the question did not specify whether all trips across the border to their country of origin were being referred to or whether responses were to be limited to visits to their town, village or area they had lived in before. Participants could classify 'home' in the way that was significant to them. Additionally, the distance from the border to the area participants are actually from or have familial ties in can influence how often a woman returns home. If her family or village is relatively close to the border and the border is accessible to her, she may return quite often. On the other hand, if she is residing in Central Thailand or if her family is quite far from the nearest border, she may seldom return. Cambodian women were the most likely to have returned home, with 89% of those surveyed having returned at least once, and 40% of those cases returning three or more times. Among Burmese and Lao migrants, 78% survey participants had returned home at least once, with about half of those cases returning three or more times.

Table 3.6: Frequency of returning home in quantitative phase

Nationality	Never	1-2 time	3-4 times	4 time or more
Lao (28)	8 28%	11 39%	9 32%	0 0%
Burmese (100)	12 12%	49 49%	19 19%	20 20%
Cambodian (100)	11 11%	53 53%	23 23%	13 13%
Total (228)	31 13%	113 49%	51 22%	33 14%

Examining possible reasons for Cambodian factory workers returning home dramatically more often than Cambodian sex workers and slightly more than Lao or Burmese factory workers, the Research Team found three interrelated explanations. To begin with, Cambodian factory workers

[27] Based on exchange rate for 6 August 2004, USD 1= 925 kyat. Source: http://www.irrawaddy.org

have a significantly higher rate of having children than workers in the other groups. In the qualitative study, many Cambodian participants reported traveling back to their homes in order to give birth and leave their children in the care of relatives or friends there. This is a major motivating factor for women to return more frequently. Additionally, a higher percentage of Cambodian factory workers reported being married and living with their husbands, allowing the couple to have more savings. During peak season though, Cambodian men were out at sea, fishing for months at a time. These savings allowed for easy travel to visit friends and family members or to bring savings back to help support relatives. Moreover, as fishery is extremely seasonal, with long slow periods when there are no boats coming in and hence no fish to process, women have excess time and can arrange for returning home, without the trip interfering with their occupational tasks or earning capacity. This is in contrast to the work schedule in other types of factories, where work is more continuous.

3.2.2 Occupational Mobility

> *Lin's first job in Thailand was to dry squid at a coastal port. She was able to get the job with the help of a neighbor from home who already had a job there. She earned six baht (USD .15) per mat of dried shrimp, which meant she earned about 100 baht (USD 2.50) every day. She had work only when they needed her. As her income was limited and she was not given a work permit, she quit and started working at a fish factory. A friend who worked there helped her to apply. At the factory, they gave her a work permit for a fee of 4,500 baht (USD 112.50). Installments were taken out of her salary every month for this. She was paid 110 baht (USD 2.75) a day for part-time work and 150 baht (USD 3.75) for longer hours. She usually worked six days a week from 6 am till 4 pm. Although the income was better, she was required to stand all day to do the work. Sometimes her legs would ache. Also, the manager was very strict about allowing people to go to the bathroom. She had to beg him each time she had to go. After seven months, she quit this job as well. She now works at another fish factory in a different port. She has worked there for about a year and is able to earn quite a bit of money when the boats come to port. She can earn 200 baht (USD 5.00) per day and about 3,000 baht (USD 75.00) per month.*
>
> *Cambodian factory worker*

Most of the women in both the qualitative and quantitative phases started factory work for economic reasons. Among the Lao factory workers surveyed, 78% cited economics as the main reason for factory work. Fourteen percent cited a myriad other reasons, including the occupational decision made by the person who accompanied them during migration. Burmese factory workers answered similarly, with 91% responding that economics was the reason they began factory work. While 78% Cambodian factory workers also listed economics as the primary reason, 12% cited adventure and curiosity as the main reason.

An 'aunt' [known elder woman] who worked in Mae Sot wrote a letter to an agent saying that the factory needed more workers. So Pha Pha decided to go with the agent – a woman from the same village who also brought the factory workers' earnings back to their families in Burma. She decided to go because it was much easier to earn money in Mae Sot.

Burmese factory worker, 20 years old

Aye-Aye's economic background is quite good. Her father is a truck driver and her mother has a food shop. They have a car and a farm, and no debts. She has three siblings. She quit her studies at the age of twenty to help her mother in the shop and also did a one-month tailoring course in Rangoon. Then she worked in a clothing factory in Rangoon for four years where she earned 5,000-18,000 kyat (USD 5.40-19.45). At the factory, she met a friend just back from Mae Sot who told her that she earned more in Mae Sot. Aye-Aye wanted to get a better salary and also see Mae Sot. So she left with two of her friends without telling her parents.

Burmese factory worker, 22 years old

Table 3.7: Reason for doing factory work in quantitative phase

Nationality	Economics	Like the job / adventure	Lured by agent	Forced by family members or relative	Other reasons
Lao (28)	22	2	0	0	4
Burmese (100)	91	2	0	0	7
Cambodian (100)	78	12	4	3	3
Total (228)	191	16	4	3	14

Half of the factory workers surveyed started working before the age of 20. Fifty-three percent Burmese participants reported the same (49% of this group started when they were 17 years old or younger). Lao participants also tended to start factory work at a young age, with 79% reporting that they started factory work when they were 20 years old or younger (of this group, 80% reported beginning factory work when they were between 15-17 years old). Cambodian factory workers, by contrast, tended to start factory work after they were 20 (61%), with another 25% starting between the ages of 18-20.

Table 3.8: Age at start of factory work in quantitative phase

Nationality	Less than 15 years	15-17	18-20	More than 20
Lao (28)	5 21%	12 42%	4 14%	7 21%
Burmese (100)	5 5%	21 21%	27 21%	47 47%
Cambodian (100)	2 2%	12 12%	25 25%	61 61%
Total (228)	12 5%	45 20%	56 25%	115 50%

As mentioned before, factory workers in the study tended not to be very geographically mobile, though they switched factories when the circumstances were better elsewhere. Of the 30 women in the qualitative phase, 19 had moved from one factory to another at least once before the time of interview, while the others had moved into factory work from a different occupational sector. Six women had done domestic work before and 5 women had worked in sales or construction.

Twenty-three percent of the quantitative participants reported having done work in other occupational sectors in Thailand before the time of survey (over one quarter of surveyed women in Lao and Cambodian groups had done other types of work in Thailand). Domestic work was the most common prior occupation reported by 21% Lao participants and 16% Cambodian participants. Five percent of Cambodian women had worked in construction before beginning factory work and 14% Lao participants had been involved in sales. Only 8% of Burmese participants had worked in other occupational sectors, as factory work is one of the most common jobs for female Burmese migrants in the research site area.

Table 3.9: Occupation before current job in quantitative phase

Nationality	Yes	No	Total
Lao	10 36 %	18 64%	28
Burmese	8 8%	92 92%	100
Cambodian	35 35%	65 65%	100
Total	53 23%	175 77%	228

While most of the quantitative survey participants said that they were not currently engaged in any work on the side, during the qualitative interviews several Cambodian factory workers mentioned doing other work. As fish processing is highly seasonal and dependent upon when fishing boats are actually in port, a number of women reported doing part-time work like selling food and vegetables near their factory to supplement their incomes. A Cambodian factory worker in Rayong made dessert and her husband helped sell them at different ports during his break-time from processing fish in the factory. They earned an extra income of about 500 baht (USD 12.50) twice a month.

Conditions and Relationships

In terms of working conditions, each of the three types of factories was structured in different ways. Working hours and wages differed, as did general trends in relationships between management and employees. Since the type of factories often influenced living conditions, in this section there will be a detailing of how participants lived, the types of assistance they expected from their employers and the kinds of violence and abuse they faced on the job. Not surprisingly, perceptions of rewards and disadvantages connected with the job differed based on the national group and the type of factory work as well.

Lao Food Processing Factory Workers

As a result of the harsh anti-migrant campaigns that were affecting Lao workers at the time, researchers had to use the Bangkok IDC to access 4 out of the 10 participants for the interview and 28 of the women for the survey. Notably however, this had the fortunate effect of diversifying the participants in this group. Prior to interviewing Lao participants at the IDC, researchers noted that they were only able to access workers in relatively positive living and working situations, as they had more freedom of movement and their employers did not prohibit them from talking with researchers. Conversely, those who were at the IDC came from a wider range of circumstances. Access to them was not determined by their working conditions and relationship with their employer. Had researchers only received responses from the former group, the data would have had clear biases towards more favorable working and living conditions. The responses in the interviews and surveys from women detained at the IDC were more varied (though there is still some evidence of this bias pattern).

Lao women in food processing factories, as noted earlier, worked in small home industries, doing food preparation tasks such as chopping, washing and packaging. The food was then either used at the restaurant where the woman worked or taken to a nearby market for being sold. In the quantitative study, 57% of the participants reported working over 10 hours a day, though 32% reported working eight to ten hours regularly. Wages among qualitative participants fluctuated depending on how long a worker had been at a certain factory or whether the employer was seen as fair or not. Even those who worked in abusive situations were earning 150 baht (USD 3.75) per day. At the upper end of the wage scale, some workers reported earning around 4,000 baht (USD 100) per month. This is closer to the Thai minimum wage standards. However, many of the Lao participants in urban areas working over eight hours on a regular basis were legally due more than they actually received. In the qualitative interviews, workers reported working from 7 am until 9

pm or later. The work-week was reported by all participants to be six days long, though there was some flexibility in more favorable situations to take time off (unpaid) for visits home.

Women worked and lived in their employer's home, usually sleeping in a large shared room above the work area. Rooms were separate for men and women but couples could have a small area partitioned off or could rent a nearby room for some private space. There were not many couples, however, as the work was largely gendered ('women's work'), except where the factory was large enough that it needed workers for packing, shipping and driving as well. As the factory staff tended to be small in number, access to bathing facilities and toilets was usually satisfactory, though in a couple of cases it was reported that there was only one toilet for up to 15 workers.

Depending on a worker's relationship with her employer, necessities besides accommodation were also sometimes made available as part of the accommodation package. Meals were provided to most of the women who were interviewed, and in some cases small food premiums were given to workers on their days off. In other favorable situations, employers also provided drinking water and an occasional toiletry, such as talcum powder. It was reported to researchers that among Lao migrants, work permits are sometimes seen as unnecessary, due to the ease with which many Lao migrants can pass off as Thai. Clearly, however, this belief has had negative consequences during government campaigns to arrest and deport migrants, as the many Lao workers being detained at the IDC during the time of research can attest to. In the quantitative group, Lao factory workers were the least likely to have a work permit – only 6 out of 28 women reported having one. Those that did have work permits in the qualitative group were often registered as domestic workers rather than factory workers, as they worked in the home of the employer.

Workers who were interviewed tended to have somewhat dichotomous relationships with their employers. Some employers were reported to exert a stringent control over their workers by restricting movement and communication among workers, and abusing them physically and sexually. In contrast, other employers were reported to be kind, and seen as akin to family members, taking care of workers and allowing them to do what they pleased on their day off. In these situations, women tended to exhibit very little occupational mobility, staying in a particular position for years at a time. Several women who reported having positive relationships with their employers had worked at the same factory for two to eight years. When quantitative participants were asked how their employer or manager treated them, 71% reported that they were treated kindly, 18% reported that their employers shouted at them regularly, and 11% simply said that

they were treated badly by their employers. Reports of violence or abuse centered on these unfavorable relationships with employers. The most commonly cited forms of abuse reported by qualitative participants were long work hours and sexual harassment. In the quantitative group, three participants reported cases of verbal and physical abuse from employers and five reported abuse from colleagues. Most of these were cases of verbal abuse. Two participants reported enduring abuse and threats from police officials.

> *Nang works in a small food processing business where the employer provides accommodation and food to all workers. "In the beginning I was harassed by my employer's husband. He sometimes touched my breast and body. I'm scared of him and try not to be alone." She didn't want to bring this to his wife's notice because she is very kind and Nang didn't want to upset her.*
>
> *Lao factory worker, 17 years old*

When asked what the best thing was about factory work, half the participants mentioned wages. Although a majority of Lao participants responded in this way, the actual percentage of women who reported wages to be the best thing was much lower than the percentage of Burmese and Cambodian women who had similar responses. By contrast, a higher percentage of Lao factory workers cited fellow workers as the best thing about factory work (28%), while 7% reported friendly employer.

Burmese Garment Factory Workers

Burmese migrant women working in factories generally reported being overworked and underpaid. Typical working hours reported by participants in both the qualitative and quantitative groups were 10-12 hours or more. Women worked from 8:00 am to 9:00 pm or from 7:00 am until 5:00 pm, with either obligatory or optional overtime (adding another two to three hours to the day). Workers had one hour off during the middle of the day for lunch and a second hour off for dinner. This was often the only free time workers had in their day. Wages were calculated on a per piece basis rather than salary, which meant they fluctuated depending on the skill required to do the specific task the woman was assigned. In the qualitative study, wages generally ranged from 1,200 baht to 2,300 baht (USD 30.00-57.50) per month, not including overtime payments. Most factories in Mae Sot provide accommodation in the factory compound and also plain rice for lunch. These could be ways to control free time and limit their choice for overtime work that pays very low wages. Accommodation provided by factory is sparse – a shared room to house 20-50 or 120 workers. Partitions are made using cardboards or with boxes meant for storing clothes.

Overtime was sometimes calculated on the same per piece basis as during normal working hours, but at some places was compensated for by giving workers a packet of instant noodles (worth about five baht/USD 0.12). In other factories, women made six or seven baht (USD 0.15-0.17) per hour of overtime, and in one particularly well-paid factory, a worker reported being given 130 baht (USD 3.25) each time she worked a full overtime shift. Minimum wages for rural areas in Thailand remains 133 baht (USD 4.00) per day, and employers are not allowed to make their workers work more than six days a week. Both these were not upheld in the factories researchers came into contact with. Factory workers tended to earn one- to two-thirds of what they were supposed to receive based on minimum wage. Employers providing shared accommodation and meals often deduct these costs from the wage. As a result, workers earn a wage lower than the minimum wage. On an average, they earned 70-90 baht (USD 1.75-2.25) a day. Additionally, most workers in the qualitative phase mentioned working seven days a week, though fewer hours on Sunday afternoons. Workers were given a full day off once a month, usually the day after receiving their wages. When the quantitative group was questioned, 45% reported working 10-12 hours per day and 50% reported working more than 12 hours on a regular basis.

Burmese factory workers in the qualitative phase almost all lived in housing provided to them by the factory management. Factory compounds tended to be large gated areas with warehouses for either working or living. The warehouses meant for living were subdivided into multiple floors, rarely more than five feet high. Men and women were on separate floors or in separate buildings depending on the size of the factory. Couples were given space in the men's sections and allotted a little more space than those who were single. Individual spaces were further subdivided by thin pieces of cardboard, wood or clothing racks. Accommodations were generally small, congested and lacked ventilation. Invariably, there weren't enough toilets and bathing areas for the number of people living at the factories, and many participants reported that the available toilets were messy and unsanitary. Many workers reported having limited time allotments for toilet use during working hours, which only made the crowds after working hours more of an obstacle.

Living place for factory workers

Garment factory management tended to provide their workers with accommodation, some electricity and limited amounts of food and water. Water was a consistent concern for workers, as factory accommodations would run out of bathing and drinking water on a frequent basis. Sometimes the water that was provided for bathing was not suitable or it was recycled.

Several women reported that the water barrels in their compound were filled with smelly or murky water. Workers also reported receiving small quantities of rice for free or discounted meals as part of their accommodation package. The food was invariably considered bad tasting and lacked nutritional value. Women spoke about pebbles in the rice, rotten produce and other indicators of substandard quality.[28] Besides these basic necessities, factory management tended not to provide their workers with any type of further assistance. In the one well-paid factory mentioned above, a member of the management team who could translate for workers accompanied them to the hospital when they needed medical attention. This assistance was notably absent in the other factories.

Work permits were provided to 9 out of 10 of the workers in the qualitative phase and to 90% of the women in the quantitative study. Of the 9 women in the qualitative phase who had registered for a work permit, 7 reported that their employers held their work permits. Workers were not clearly educated on the benefits of having a work permit, including entitlements such as reduced health care insurance in government hospitals. The workers who were provided with work permits usually paid over 4,000 baht (USD 100) for them, with deductions of around 300 baht (USD 7.50) per month being made from their salary. These amounts were not always made clear to them by the factory management, and this sometimes resulted in overpayment for their permits.

Employers in this group were often interpreted as formal and inaccessible to workers. The women interviewed did not feel that their employer was someone who they could negotiate with or ask for extra provisions, such as medical assistance or leave when needed. While a majority of surveyed participants (68%) reported that their employers treated them kindly (supportive), a significant number (32%) reported that their manager treated them badly (looked down upon or insulted them). Almost all employers demanded that their workers work well beyond the time permitted by Thai labor laws. On a related note, 100% of qualitative participants reported working extensively long hours. Other abusive conditions were also reported to occur frequently by Burmese participants. All 100% participants in the qualitative study reported cases of verbal insults and abuse, while 70% reported having been threatened with arrest at least once. Additionally, 30% reported cases of sexual abuse. In the quantitative group, reports of abuse were considerably lower. Ten percent of those surveyed reported accounts of abuse from employers or managers, half of those being cases of verbal abuse. An additional 3% reported suffering abuse at

[28] A researcher had lunch at the factory where she was interviewing a factory worker. She reported to the team that the food was well below satisfactory and was obviously lacking in nutritional content.

the hands of colleagues. Such difference in numbers was no doubt due to the difference in levels of trust and intimacy formed during the interviews vis-à-vis the survey process.

In view of the working conditions in garment factories, it was not surprising that a quarter of the Burmese factory workers surveyed reported that the worst thing about their job were the long work hours and low pay. Bad living conditions were reported to be the worst thing by 29% of participants, while smaller percentages classified not getting paid their promised salaries, not being paid on time and verbal insults from their supervisors as being the most negative. Ten percent of participants reported that there was nothing bad about their work. When Burmese factory workers were surveyed about the best aspect of their current work, a clear majority (63%) reported that their income was the best thing. Fifteen percent of women reported that having a friendly employer was the best thing, while another 15% mentioned that they felt safe at work, and that was the best thing about their current job. These responses correlate to the particular situation Burmese migrants face. Even though the wages they earn in Thailand are below national limits, Burmese workers still earn considerably more than they would at home. Additionally, having a space to work where they feel safe is a significant comfort in their lives, especially as they risk penalties and punishments by officials in Burma if they are deported.

Cambodian Fish Processing Factory Workers

Fish processing is highly seasonal and dependent on company fishing boats returning to port loaded with fish ready to be processed and sent to markets. Women tend to work early morning hours in order to prepare the fish for shipping out in the afternoon. Women in the qualitative interviews reported starting at 6:00 am or as early as 3:00 am and working about ten hours until the load was completely finished. Nearly half of the participants were unable to estimate their working hours per day due to the seasonal nature of their work. Sometimes, the quantity of work varies even in high season. Among quantitative participants, only 57% participants responded to questions about their working hours; the others felt their work was too irregular to properly comment. Among those who responded, 23 reported working ten to twelve hours or more every day, 19 reported working eight to ten hours, and 15 reported working less than eight hours (these were in less busy port areas).

Table 3.10: Estimation of work hours per day in quantitative phase

Nationality	Less than 8 hrs	8-10 hrs.	More than 10-12 hrs.	More than 12-13 hrs.
Lao (28)	3 11%	9 32%	14 50%	2 7%
Burmese (100)	4 4%	2 2%	45 45%	49 49%
Cambodian (57)*	15 15%	19 19%	20 20%	3 3%

*Only 57 Cambodians were able to estimate their working hours/day due to the unpredictable nature of work.

Women in this group were primarily paid on a per piece basis (based on the kilogram, a full basket or a full box). This contributed to their irregular earnings. In the qualitative group, most of the participants reported earning 150 baht (USD 3.75) per day. The Thai minimum wage in the area is 133 baht (USD 3.32). Wages ranged from 150 to 200 baht (USD 5.00) per day. However, there was variation as one woman reported earning as little as 100 baht (USD 2.50), whereas another reported earning up to 300 baht (USD 7.50) per day. This same participant explained that on a per day basis she usually earns between 200 and 300 baht, but can only earn up to 3,000 baht (USD 75.00) every month as the work is so irregular. In view of this situation, it is easy to see why several interviewed participants reported doing other jobs in addition to fish processing. Women who took up work on the side reported selling desserts, working in laundry shops or providing other small services for community members. While these jobs were monetarily tenuous, they did offer workers more freedom in movement and schedule than did factory jobs. Two women in the qualitative group mentioned that they are able to work a couple of days per week without their husbands knowing. Flexible schedules also allowed for more travel time. Not surprisingly, the Cambodian factory workers had the highest rates of returning home among the three groups in the quantitative study.

The Cambodian participants tended not to live in places tied to their work establishments. Only two of the ten women interviewed lived at the factories where they worked. In the other cases, women rented small rooms in nearby areas for 300-1,000 baht (USD 75-100) per month and shared them with a family member or friend. In half of the interviews, women reported living with their husbands or boyfriends, whereas the others who rented rooms lived with their sister or a friend.

As workers in this group were older and more independent of their employers than members of other national groups, women generally did not report having provisions made available to them by their employers. Exceptions did exist if workers had grown close to their employer as a result of working at a specific place for a longer period. Even though these extra provisions were rare, relationships between workers and their employers in this group were generally positive. Cambodian factory workers who were surveyed often rated their relationships with their employers as favorable, with almost 89% reporting that their employer or manager treated them kindly. This was the highest percentage in the three groups. However, only 64% of quantitative participants reported that they were offered work permits by their employers. Those who were offered work permits in the qualitative phase had deductions from their pay to cover the cost of the permit, although this was not asked about in the quantitative survey. The low rate of work permits testifies to the irregularity and informality of the work structure in fish processing.

Reports of violence and abuse in this group were the lowest among the three national groups. This could potentially be due to several reasons: the strong presence of the community, workers residing in separate living accommodations and the positive relationships many workers had with their employers and colleagues. In the qualitative group, there were two reports of verbal and physical abuse. Notably, domestic abuse was more of a concern in this group than in the others. During interviews, women reported worries about their husbands' drinking habits and extramarital relationships. In the quantitative survey, only 1% reported being threatened by their employer, while 3% women reported facing verbal abuse from other colleagues, and the same percentage reported facing verbal abuse from police officials.

Table 3.11: Treatment by employer in quantitative phase

Nationality	Kind to me	Treats me badly	Gives more work	Always shouts	Always verbal insults
Lao (28)	20 71%	3 11%	0 0%	5 18%	0 0%
Burmese (100)	68 68%	32 32%	0 0%	0 0%	0 %
Cambodian (100)	89 89%	2 2%	4 4%	3 3%	2 2%
Total (228)	177	37	4	8	2

The majority of responses centered on economics, when asked about the most positive aspect of factory work. Speaking about the worst aspect of factory work, 49% respondents reported the long work hours and low pay, and 35% reported a cruel manager. Additionally, 9% mentioned

bad living conditions as the worst thing about factory work. Regarding the best thing about factory work, 70% women reported the income earned as the best aspect. Twelve percent women described their friendly employer as the best aspect, while 6% reported having nice colleagues as the best part of factory work. Eleven percent women responded that the best thing about factory work was that it provided a safe place for them. This response is not to be underestimated in the experience of migrant workers, as concerns about safety, particularly from the police, played a significant role in all qualitative interviews.

Table 3.12: The best thing about factory work in quantitative phase

Nationality	Income	Kind employer	Nice colleagues	Safe place to stay	Others
Lao (28)	14 50%	2 7%	8 28%	1 3%	3 11%
Burmese (100)	63 63%	15 15%	2 2%	15 15%	5 5%
Cambodian (100)	70 70%	12 12%	6 6%	11 11%	1 1%
Total (228)	147 64%	29 13%	16 7%	27 12%	9 3%

Table 3.13: The worst thing about factory work in quantitative phase

Nationality	Cruel/violent employers	Long working hours & low wages	Bad living & working conditions	Others	No bad things
Lao (28)	2 7%	3 11%	2 7%	12 43%	9 32%
Burmese (100)	7 7%	25 25%	29 29%	29 29%	10 10%
Cambodian (100)	35 35%	49 49%	9 9%	1 1%	6 6%
Total (228)	44 19%	77 34%	40 18%	42 18%	25 11%

3.3 General, Occupational and Reproductive Health

3.3.1 General Health

Gathering information on the actual state of health of migrant women was as important as it was to assess how the workers in this phase perceived their own general health and their health awareness. When the quantitative group was questioned about whether they thought they knew enough about their health and body systems to be able to take care of themselves, Burmese

factory workers responded with the highest percentage of positive responses (nearly 90%). Six percent of Burmese factory workers said that they did not know enough and 5% responded that they were not sure if they knew enough. Cambodian factory workers' responses were less self-assured: 61% said that they felt they knew enough about their health and body systems, 17% responded that they did not know enough and 21% said that they were unsure. In contrast, only 17% of Lao factory workers responded that they felt they knew enough, 46% responded that they did not know enough and 35% reported that they were unsure. These differences in numbers may be partially attributed to differences in health trainings and outreach programs available in each area and to each national group. This trend held true across all three sectors of migrant workers in the study.

Table 3.14: Knowledge of health and body systems for self-care in quantitative phase

Nationality	**Yes**	**No**	**Not sure**
Lao (28)	5	13	10
Burmese (100)	89 89%	6 6%	5 5%
Cambodian (100)	61 61%	18 18%	21 21%
Total (228)	155	37	36

In both the Burmese and Lao factory worker groups, more than half of the women surveyed (64% and 60% respectively) reported that they would describe their health as either good or very good. In the Cambodian group, 47% of the women surveyed reported the same, though 21% women reported that they would describe their health as rather poor or very poor. In both the Cambodian and Burmese groups, about a third (32% and 30% respectively) of the women reported they perceived their health as average. Seventeen percent Lao women said the same, while 21% said that they had either rather poor or very poor health. Burmese women had the lowest percentage of respondents reporting poor health (5%). This did not, however, consistently mirror patterns in responses to whether respondents currently had general health problems or not. While only 5% Burmese women reported having poor health, 68% of women reported having a current general health problem. This was a significantly higher rate than the women in the Lao group: 17% of them reported having poor health and 42% reported having a current health problem. Women in the Cambodian group had the highest rate of reporting a general health problem, with 82% of women reporting this to be the case. This was less surprising as many of them had reported poor health.

Table 3.15: State of health in quantitative phase

Nationality	Very/fairly good	Average	Rather poor	Total
Lao	16 57%	7 25%	5 17%	28
Burmese	64 64%	31 31%	5 5%	100
Cambodian	47 47%	32 32%	21 21%	100
Total	127	70	31	228

3.3.2 Occupational Health

Factory workers from all three national groups and in both the qualitative and quantitative phases showed signs of their health being dramatically affected by their occupation. In all three migrant groups and during both phases, women reported having regular headaches (attributed to work stress), and strain on the eye (due to intense concentration on detailed tasks and working under bright lights for long hours). Additionally, during the qualitative phase, 11 out of 30 factory workers reported having urinary tract infections, most likely due to limited access to both safe drinking water and toilet use during work hours. Other factors may include obstacles to using the toilet, such as having to negotiate through cramped quarters during the night or concerns about safety when toilets are in a separate area.

Some symptoms were very specific to the type of work a particular group performed. In the qualitative phase, Lao women in food processing discussed having digestion problems, little appetite and tiredness as some of their main general health symptoms. Workers reported that working with food throughout the day made them significantly less interested in eating and when they did eat, they were often substandard portions or at irregular times. All these factors, plus a cultural preference for heavily spiced food, appeared to lead to reports of regular pain from acidity, diarrhea and constipation. Women who worked in less favorable conditions commented on being tired and feeling weak due to lack of regular sleep and exhaustion from working long hours. Lao factory workers in the quantitative phase also reported regular headaches and pain from acidity.

Burmese factory workers in the qualitative phase discussed occupation-related health symptoms such as chronic coughs or respiratory problems, severe headaches and skin infections. In garment

factories, fine dust from both natural and synthetic cloth circulates in the air, often infecting lungs and inducing allergic reactions. Constant exposure to this dust makes it difficult to recover from respiratory illnesses. Although masks were reportedly given, only in a few factories were workers told about their benefits and how to use them properly. In none of the factories was it mandatory for workers to wear facemasks when working with dust-producing fabrics.

As accommodation provided for workers was almost always substandard, workers also suffered from the effects of poor living conditions. Several of the women interviewed mentioned bathing water being used over and over again, leading to skin infections and a host of reproductive health problems. Crowded living quarters also meant women had a high exposure to infectious diseases, including cold and flu. Since there was hardly any ventilation and often no space to dry washed clothes, women reported going to work wearing damp clothes. On a related note, because of substandard food options provided to the workers, many women reported feelings of general weakness and deteriorating immune systems. Thirty-three percent of Burmese factory workers in the quantitative phase reported having headaches regularly, while 12% reported cases of back and body pain, due to the restrictive postures and repetitive actions performed during long working hours.

Cambodian factory workers in the qualitative phase had similar symptoms of back and joint pains, headaches and skin infections. Processing fish can involve repetitive motions or lifting heavy loads for many hours at a time. Over half of the women discussed having back pains, and most women considered their working posture as a reason for this pain. Another 4 out of the 10 women interviewed reported having joint pain as a result of repetitive motions while on the job. Three out of the ten women in this group talked about skin infections that developed or were made worse by exposure to wet surfaces or air-trapping gloves during their work days. As with the other groups, headaches were reported by 66% of the women in the quantitative study. Since women in this group were older and had given birth more often than women in the qualitative groups, there was a significant increase in women discussing birth-related problems, such as particular body pains that had been part of their lives ever since. In the quantitative study, 30% women reported having back pain, while 3% reported having joint or body pains in addition.

Table 3.16: Current general health problems in quantitative phase

Current general health problems	Laos	Burma	Cambodia
Asthma	0	4	0
Back pain	2	8	28
Body pain/ weakness	1	7	2
Headache	4	34	60
Blood pressure	0	5	0
Chest pain	0	1	0
Dizziness	0	2	4
Flu	1	1	0
Leg/knee/ shoulder /joint	0	2	1
Palpitation	0	1	1
Stomach ache	0	2	1
Migraine	0	0	1
Acidity	2	0	1
Fever	0	0	1
Anemia	1	0	0
Total	11 (28)	67 (100)	100 (100)

Treatment

Women's responses to their health problems ranged from ignoring the problem to seeking medical assistance. Generally, seeing a doctor for a health problem was not a common option. Twenty-four percent of the quantitative group with current health problems reported that they had seen a doctor in the last six months. Within that group 45% were Burmese, meaning that over a third of the Burmese workers who had a health problem addressed it by seeking medical assistance. This is in vivid contrast to the mere 13% Cambodian and 5% Lao women who had a health problem and went to see a doctor. The Research Team sees direct connections between these numbers and the number of health-related NGO projects serving the Burmese migrant community in the research site. Twenty percent of the Burmese workers who reported having a health problem self-medicated and another 29% reported not being sick in the last six months.

While this response might be seen as contradicting their previous statement of currently having a health problem, it can also be interpreted as workers feeling that they were not sick enough to warrant seeing a doctor or taking medication. Similarly, in the Cambodian group of factory workers who were surveyed, 10% of those who reported currently having a general health problem also reported not being sick in the last six months. Sixty-nine percent of Cambodian women who said they currently had a health problem reported addressing it through self-medication, while 80% of Lao factory workers did the same.

Table 3.17: Awareness of health problems in past six months in quantitative phase

Nationality	Have problem in past six months	Never got sick
Lao (28)	20 71%	8 29%
Burmese (100)	71 71%	29 29%
Cambodian (88)	88 88%	12 12%
Total (228) 100%	179 79%	49 21%

Table 3.18: Addressing health problems in quantitative phase

Nationality	Saw a doctor	Self-medication	Ignore it
Lao (20)	1 5%	16 80%	3 14%
Burmese (71)	32 45%	14 20%	25 35%
Cambodian (88)	11 13%	61 69%	16 18%
Total (179)	44 24%	91 51%	44 24%

Self-medication

> *"Whenever I get sick, my husband buys medicine for me from the drug store because he can explain it better to the seller."*
>
> *Cambodian factory worker*

For self-medication, painkillers, specifically paracetamol, were the most commonly used medicine among the quantitative group of factory workers. Of the Burmese women who said they were taking medication currently, 85% reported taking paracetamol on a regular basis, as also 55% of Lao and Cambodian women. Among Burmese participants, antibiotics were the second most commonly taken medicine, while for Lao participants, digestion aids were the second most common medicine. Within the Cambodian group, several women reported taking other types of painkillers and herbal medicines on a regular basis. This supported findings from the qualitative phase in which participants talked about taking traditional and herbal medicines with significant regularity. Among Burmese participants this was particularly true. They are more likely to seek traditional medical assistance than allopathic cure, but women from Laos and Cambodia also mentioned doing this. On a different note, Cambodian women more often referred to other members of their community, who they trusted or who had experienced similar problems. Several Cambodian workers referred to discussions they had had with friends or relatives on whether to seek medical treatment at all. As many women in this group were married, husbands had the

authority to decide whether medical assistance should be sought and what the process of seeking assistance should be (for example, taking the woman to the doctor and/or picking up medicines).

3.3.3 Reproductive Health

Awareness

Awareness of reproductive health issues (in particular, contraception and STIs) varied among the three groups in qualitative interviews. Among Lao and Cambodian factory workers, knowledge of contraception methods was fairly limited. However, several women had some degree of understanding about a specific contraceptive method that friends or family members had used. In the Cambodian group, awareness of both contraceptive methods and STIs indicated that the participant had been able to access the local AIDS NGO that did outreach campaigns around the research site. In the locations used to reach Lao migrants there was no such organization working with Lao migrants, so women knew significantly less about related issues. Factory workers in the Burmese group benefited the most from local health organizations, as many of them had been through training programs and, therefore, were more aware of a range of contraceptive options and STI risks. These health organizations also distributed condoms and oral contraceptives through factory outreach campaigns, which directly influenced Burmese participants' ease of access to these contraceptives. In the quantitative survey, responses were similar, though they did not match these patterns directly. Among Lao participants, 39% of those surveyed reported never having received health information, which was actually lower than both the Burmese group at 50% and the Cambodian group at 48%. Similarly, 28% of Burmese women reported that they had received some piece of information about HIV in the past, whereas 42% of Lao and 48% of Cambodian women reported the same. Three percent Lao, 11% Burmese and 7% Cambodian women reported receiving information about STDs in the past.

Table 3.19: Receiving health information in quantitative phase

Information received	Laos (28)	Burmese (100)	Cambodian (100)
HIV	15	8	21
Cancer	1	0	5
Contraceptive	4	2	15
Menstruation	12	2	8
Safe sex	1	2	13
STI	5	3	7
Never received any	11	50	48

Each participant selects 3 topics most frequently received.

Sexual activity, condoms and other contraceptive methods

In terms of actual contraceptive use, factory workers in the qualitative group had varied responses. This variation can be attributed, in part, to the differences in sexual activity rates among the three groups. In food processing factories, Lao women were generally not allowed to have their boyfriends or husbands stay with them unless they worked at the same factory. This was rare as factories are small scale and have only female workers. Some Lao participants in the qualitative phase did report entering into relationships with men who worked nearby and spending some time with them on their days off. Burmese factory workers had slightly more opportunities to enter into relationships within the community of factory workers, as the factories were sometimes mixed. However, sexual activity was mainly mentioned by those who were married. Cambodian women were older and in partnerships more (often) than the women in other groups. Living independently, outside the confines of a factory, permitted new sexual relationships to begin and provided freedom to live with a pre-existing partner.

In all three groups there was a high incidence of women starting with either oral or injectible contraceptives and stopping quite quickly due to side effects. As in the case of sex workers, this was attributed to low levels of counseling and assistance from health providers. Had women received more assistance, they may have had a better understanding of the reduction in side effects after prolonged use and known more about what forms of contraception might be best for their situation. Five of the Lao women interviewed had tried oral contraceptives or were currently taking them, and there was one case each of condom and injectible contraceptive (Depo-Provera) use. In the Burmese group, four women interviewed had tried oral contraceptives or were currently using them, while two had tried injectible methods and one was using condoms with her husband regularly. Burmese participants were able to purchase oral contraceptives cheaply from trades-people who came to the factory to sell simple provisions or NGO workers who distributed them for free. In the two cases of using Depo-Provera, both had received them while in Burma. As Cambodian participants were more regularly in partnerships, many of them had tried different contraceptive methods. Seven of the ten women interviewed had taken oral contraceptives before or were currently using them, while two had been using the injectible contraceptives. Several women explained that the contraceptives were brought to Thailand by Cambodian women and sold to members of the migrant community. None of the Cambodian women interviewed reported using condoms with their partners.

In all three qualitative factory worker groups, women discussed the use of condoms being strongly related to levels of trust in their relationships. This was particularly true among members of the Cambodian group, many of whom reported that the reason they did not use condoms was that they trusted their husbands. It was reported that male partners and participants themselves perceived condoms as being for use between men and sex workers rather than for long-term partners. In both the Lao and Cambodian groups, women expressed this attitude even when they knew that their partners were sexually active with others. Many women described symptoms of vaginal infections. Only one Burmese woman reported using condoms to protect her husband from potential infections. In a few cases, however, women reported having been infected with STI by their husbands, though this did not influence their standing decision not to use condoms.

Seventy-five percent of the Cambodian quantitative participants reported being married, which mirrored the 7 out of 10 married qualitative participants. Seventy-five percent of the Cambodian quantitative group reported they were sexually active, the highest percentage among the three migrant groups, and 20 reported using oral contraceptives. Condom use among quantitative participants was also rarely reported. Nine of the ten Lao factory workers reported using the oral pill as a form of contraception, and one woman reported using condoms. This was higher than among the Burmese (1 out of 40) and Cambodian (none out of seventy-five) participants. In the Burmese group, nine women reported using injectible methods. A remarkably high number of Cambodian women reported they did not use any contraceptive methods because they wanted a child; 8 Burmese women reported the same.

Table 3.20: Use of contraceptive method to avoid pregnancy in quantitative phase

Nationality	Oral pill	IUD	Depo-Provera	Condom	Other	Not fertile	No, want child
Lao (10)	9	0	0	1	0	0	0
Burmese (40)	17	0	9	1	3	2	8
Cambodian (75)	20	1	9	0	1	8	36
Total (125)	46	1	18	2	4	10	44

Reproductive Health Problems

While the Research Team noted a high degree of initial embarrassment and resistance to talking about reproductive health issues, once the qualitative group of factory workers established a level of comfort with the researchers, many readily discussed reproductive health problems and disturbances they had encountered. Sixteen participants reported painful periods, heavy and irregular bleeding, absence of menstruation, severe cramps or passing of blood clots. These were all categorized as menstrual disturbances. Additionally, 21 out of 30 participants discussed having symptoms that fell into the category of vaginal infections/PIDs, including foul smelling discharge, pain and severe itching in the vaginal region. Five women reported having severe lower back and abdominal pain during intercourse. The typical response to these problems was to ignore them or to use traditional practices and medicines rather than seek medical treatment from a physician. Examples of traditional practices and medicines that were reported include washing vagina with water left over from washing rice to reduce discharge, avoiding spicy foods to help menstrual flow and taking herbal medicines. The reasons given for not seeking medical attention were: embarrassment, thinking that their problem was normal, and the fear of getting arrested. In the Burmese group, seeking traditional treatment was nearly twice as often as seeing an allopathic doctor. Three out of ten Burmese women did see a doctor for their reproductive health problems, the highest occurrence among the three qualitative groups. In the Cambodian group, there were a number of cases of women discussing their health problems with family members and being influenced by them in their decision to seek medical assistance. In several cases in all three groups, ignoring minor symptoms led to severe cases of infection including regular profuse discharge and itchiness. In the Burmese group in particular, infections were attributed to poor living accommodations. Washing with dirty or recycled water was reported to spread infections among factory residents. Moreover, as living accommodations were almost always crowded and lacking in ventilation, women often had to wear damp clothes leading to fungal infections and skin rashes.

Table 3.21: Reproductive health problems in qualitative phase

Ailment	Burmese (10)	Cambodian (10)	Lao (10)	Total (30)
Menstrual Disturbance	6	3	7	16
Vaginal Infections/ PID	7	6	8	21

***** Women could choose more than one.

Since the survey process did not build the same kind of trust and communication as the in-depth interview process did, responses about reproductive health were less candid in the quantitative

group. When asked about current health problems, only 3% provided reproductive health-related symptoms out of the total group of surveyed women (namely irregular menstruation). Reported rates were also low for cases of STIs, though this may also be due to varying levels of awareness about STIs and their indicators in general. Among Lao participants, only 3% reported ever having an STI, though another 3% were unsure. In the Burmese group, rates were highest for participants being sure that they have had an STI (12%), while another 6% of Burmese women reported that they did not know. In the Cambodian group, 6% women reported that they had had an STI before, while 13% said that they didn't know.

Though most participants reported having a test for HIV as part of the work permit application process, the Thai government denied that there was any such mandatory blood test. When asked about being tested for HIV, researchers did not ask participants what the results were but whether they knew their results. In all cases of Lao women being tested for HIV (10% of the group), no one had been told their results. This is in contrast with the 3% Burmese women who had been tested and were told about their results. Testing rates were dramatically higher in the Cambodian group, where 51% women reported having been tested, after which 96% of those cases were told their results. This may be due to the medical assistance offered by an NGO working in the research site.

Table 3.22: STI examination in quantitative phase

Nationality	Yes	Never	Don't know/ not sure
Lao (28)	0 0%	25 89%	3 11%
Burmese (100)	12 12%	82 82%	6 6%
Cambodian (100)	6 6%	81 81%	13 13%
Total (228)	18 8%	188 82%	22 10%

Table 3.23: Tested for HIV in quantitative phase

Nationality	Yes	No, never	Don't know/not sure
Lao (28)	1 3%	25 89%	2 7%
Burmese (100)	3 3%	95	2 2%
Cambodian (100)	50 50%	47 47%	3 3%
Total (228)	54 24%	167 73%	7 3%

Pregnancy and Abortion

Factory employers have been known to fire women for being pregnant. In order to keep their jobs and avoid repatriation, young migrant women with unplanned pregnancies resort to having unsafe abortions. It is significant that the health exam for registrations includes a pregnancy test, the results of which are given to the employer to decide on the continuation of employment.

Generally, women working in all three of the factory types were not encouraged to get pregnant by the conditions of their employment. Women in all three groups discussed pregnancy as a risk to employment. It was only in the Cambodian group that a significant number of women reported trying to get pregnant or planning for a pregnancy. Notably, more women in this group were also married and of an older age than those in the other groups. Living conditions for Cambodian factory workers were also more conducive to coupling, as most women rented separate rooms or homes that they shared with their husbands or other family members.

In both the Lao and Cambodian qualitative group, women discussed a significant preference for delivering their children at home, where there was more community support and TBAs (traditional birth attendants) available. A distinction between these groups did appear in the interviews regarding this preference. While Cambodian women were not receiving pre- or post-natal care from health care providers in Thailand during and after pregnancy, Lao women reported being able to access medical assistance in Thailand prior to their departure to Laos to actually give birth. Women in this group were often assisted by their employers in seeking such medical attention or were able to pass off as northeastern Thais at hospitals or clinics.

Within the group of surveyed Lao women, 7 out of 28 reported having been pregnant at least once before. Of these cases, all reported having one live birth each and no miscarriages. In contrast, 76% of Cambodian women reported having been pregnant at least once before 21, and of them at least one reported a miscarriage. Thirty-four Burmese women reported having been pregnant before, while 29 of that group reported having had live births. Within that group, 15 Burmese participants reported having had one miscarriage or more, while four reported that they had either had a stillborn or ectopic pregnancy before. Eight Cambodian participants reported the same.

Table 3.24: Reporting pregnancy in quantitative phase

Nationality	**Yes**	**Never**
Lao (26)	7 26%	19 73%
Burmese (100)	34 34%	66 66%
Cambodian (100)	76 76%	24 24%
Total (226)	117 52%	109 48%

2 Lao participants did not respond.

As abortion is illegal in Thailand (except in cases of risk to the woman's life or in some situations of sexual abuse),[29] women who want to terminate unwanted pregnancies generally have unsafe abortions that are either self-induced or done by traditional birth attendants, both trained and untrained, or carried out by other members of their community. Crude and dangerous equipment and methods are often used.[30] There were rare cases in the overall study when participants mentioned having abortions in private clinics, though this was prohibitively expensive and did not guarantee a safe procedure. In the qualitative group, 3 out of 30 women discussed having had prior abortions, and two of those cases led to complications afterwards.

In the quantitative group, 9 Burmese women and 13 Cambodian women reported having had one abortion or more. Lao women did not report any incidents of abortion, though reported rates among all participants may be lower than actual rates due to the sensitive nature and stigma associated with the subject matter.

Table 3.25: Pregnancy results in quantitative phase

Nationality	Live births	Miscarriages	Abortion	Other, e.g. still born
Lao (7)	7	0	0	4
Burmese (34)	29	15	9	4
Cambodian (76)	64	21	13	8

* Women could choose more than one.

[29] Lerdmaleewong, Malee and Caroline Francis. "Abortion in Thailand: A Feminist Perspective." *Journal of Buddhist Ethics* 5, February 1998, 22-48.

[30] Methods reported to researchers to induce a miscarriage: insertion of sharp pieces of wood, candles and medicinal or herbal compresses; use of hot stones or rough massage techniques on the lower abdomen; and consumption of traditional and allopathy medicines in toxic amounts.

3.3.4 Psychological Well-Being

In order to gain a fuller picture of the lives and general health of migrant workers in the study, participants were asked about their mental and emotional health in both the qualitative and quantitative phases. In the qualitative study, the stress of being a migrant was made clear in women's discussions on being upset, stressed or fearful in their daily lives. Eleven out of thirty participants interviewed described feeling regularly upset, while six women talked about stress. Six women discussed feelings of fear of arrest, while another four women talked about loneliness. Three women discussed feelings of depression or sadness, though in the quantitative group, reports of depression shot up with half of the participants reporting depression in their work. Both Cambodian and Lao quantitative participants had high rates of depression (69% and 64%, respectively), while in the Burmese group, 25% said the same. When asked more generally about their mental and emotional health symptoms, insecurity (41 women) followed by stress (38 women) were the most commonly reported symptoms. Twenty women reported feeling upset on a somewhat regular basis.

Table 3.26: Reporting depression in quantitative phase

Nationality	**Yes**	**Never**	**No answer**
Lao (28)	18 64%	8 28%	2 8%
Burmese (100)	25 25%	73 73%	2 2%
Cambodian (100)	69 69%	31 31%	0 0%
Total (228)	112 (49%)	112 (49%)	4 (2%)

Table 3.27: Current mental health in quantitative phase

Current mental health	Lao	Burma	Cambodia	Total
Boredom	1	1	9	11
Insecurity	1	22	18	41*
Missed home	1	6	2	9
Sadness	1	1	10	12
Sleeplessness	1	6	11	18

Stress	14	22	2	38*
Worry/fear	2	1	14	17
Loneliness	0	7	7	14
Mood swing	0	1	5	6
Upset	0	3	17	20

*Women could choose more than one.

Within the qualitative group, response activities to cope with these mental and emotional health symptoms ranged from spending time alone to drinking, though the most commonly cited responses (3 out of 20 cases) were crying, talking to friends and, alarmingly, attempting suicide. In the quantitative study, the most commonly reported coping activities were talking with friends/relatives (including husband/boyfriend) and trying to forget the problem.

Table 3.28: Coping mechanism in qualitative phase

Coping activities	Lao	Burmese	Cambodia	Total
Crying	2	2	19	23
Talk to friends	8	4	25	37
Talk to husband/boyfriend	4	0	2	6
Talk to sister/relative	1	0	0	1
Try to forget	0	7	16	23
Fight back	0	2	0	2
Concentrate on work	0	1	0	1
Drinking	0	0	1	1
Work harder	0	0	1	1
Do nothing	2	0	0	2

3.4 Access to Health Care Services

The level and quality of health services accessed by migrant factory workers were diverse and connected to outside circumstances – wages being deducted for taking time off, not being allowed to take time off, no Thai language skills or translator assistance, the fear of arrest at the health care establishment or in the transportation process, being too embarrassed or too intimidated by health care professionals to properly discuss health problems, and the costs of travel. As a result, women reported preferences for seeing traditional healers in their communities, self-medicating with traditional or allopathy medicines and having limited consultations with trained and

untrained pharmacy staff (in either Thai or their native language). Many women also reported that they ignored health problems, which often led to the problem becoming worse.

In the qualitative interviews there was a dramatic mix of experiences in accessing health services. In the ten interviews with Lao women, there were five positive cases of accessing health services. These five cases were all directly influenced by the women's ability to pass off as Thai, being able to speak Thai language, and having employers assisting them with the process. Employer-assistance was usually offered by accompanying the women to the appointments and, in some cases, paying for the services and medicines. In four other cases, women reported never having tried to access health services in Thailand. In 3 out of these 4 cases, women explicitly stated that they had not sought medical attention due to being illegal migrants. In all four of these cases, self-medication was also mentioned during the interview. Six out of ten Cambodian participants discussed having positive experiences in accessing health services. These experiences were also directly influenced by the level of Thai language skills women had, the availability of translators, or being assisted by a staff member of a local NGO. In two of these cases, women said that they had received good treatment at private clinics, but that the services were very expensive, ranging from 130-150 baht (USD 3.25-3.75), the same as their daily wage and significantly higher than the Thai government's 30-baht health insurance scheme offered to registered migrant workers and the Thai people. Three Cambodian women described negative experiences while accessing health care services, which included situations of negligence and the health care providers being unwilling to provide clear explanations about what was happening. In one case, a nurse threatened the woman with arrest, based on the fact that she did not have a work permit in her possession. Burmese responses with regard to negative experiences were similar, as two women spoke about the expense of private clinics and their embarrassment at communicating through a male translator. Three Burmese women reported never having accessed health services, as they did not have a translator from the factory to go with them. They were scared to go alone and they preferred self-medicating. Six women reported positive experiences at the Mae Tao Clinic, an active NGO health clinic specifically designed to address the health needs of Burmese migrants around the research site. They provided translators or staff who could speak Burmese and were experienced in servicing the migrant population. Unfortunately, this positive service did not reduce the fear of arrest at least one woman felt in the transportation process.

3.5 Future Plans

Imagining or making future plans can be highly tentative for migrants, particularly those working without work permits or documentation in their destination country. Accentuating their feeling of insecurity are other fears – arrest or deportation, inability to negotiate for wages, and violence and abuse at work. Yet, having a goal to reach can result in more focused choices. At the time of closing the interview and survey process, it was important to support the participants who did have a future plan by listening to them and to encourage the ones who didn't by asking them to voice their thoughts about the future. In general, the Research Team felt that in discussing their future plans, participants demonstrated their agency, self-reliance and determination.

Table 3.29: Plan to stay in current employment in quantitative phase

Nationality	Less than 6 months	6-12 months	More than 12 months	Don't know / no plan
Lao (28)	2 7%	3 11%	2 7%	21 75%
Burmese (100)	17 17%	22 22%	35 35%	26 26%
Cambodian (100)	9 9%	3 3%	11 11%	77 77%
Total (228)	28	28	48	124

While 27% of the quantitative group specifically reported that they did not have a plan, many participants discussed what they wanted to do in the future. Seven Lao participants wanted to have a farm or work on a farm at home, while five women reported they wanted to open a shop at home. Sixty-five Burmese participants reported that they also wanted to run a shop at home, while 14 reported wanting to work on or have a farm. The Cambodian group had the highest number of women (47) reporting not knowing their future plan. Fourteen reported wanting to have a shop at home and eight reported desiring a farm or work on a farm at home.

Table 3.30: Future plans in quantitative phase

Future plan	Lao (28)	Burmese (100)	Cambodian (100)	Total (228)
Have a shop at home	5	65	14	84 37 %
Stay here	2	0	0	2 1%
Rice field/farm at home	7	14	8	29 13%
Stay with family/children	1	8	14	23 10%
Continue studies	0	3	0	3 1%
Run a business	0	8	12	20 9%
Beauty salon	0	0	5	5 2%
No plan/don't know	13	2	47	62 27%

3.6 Conclusion

Migrant factory workers are employed in food processing, garment and fish processing factories. Economics is the prime motivation for women to leave home to work in factories in Thailand. Burmese and Lao women tend to start factory work before the age of 20, while Cambodians normally start factory work after the age of 20. A majority of migrant women did not have work experience in other occupational sectors. Generally, factory workers were found to be not very geographically mobile, though they changed factories if circumstances elsewhere were better.

Factory workers showed signs of their health being dramatically affected by their occupation. Women reported having regular headaches and strain on the eye. Over half of the women in the qualitative phase reported having urinary tract infections. This was most likely due to limited

access to safe drinking water and the toilets during work hours. Other factors may include obstacles to using the toilet, such as having to negotiate through cramped quarters during the night or concerns about safety when toilets were in a separate area.

Other symptoms and their occupational links were more particular per group and type of work performed. Lao workers reported having digestion problems, little appetite and tiredness as some of their main general health symptoms. Women who worked in less favorable conditions commented on being tired and feeling weak due to inadequate sleep and exhaustion from working long hours. Lao factory workers in the quantitative phase reported having acidity and regular headaches. Burmese women discussed occupation-related health symptoms, such as chronic coughs or respiratory problems, severe headaches and skin infections. In garment factories fine dust from both natural and synthetic cloth circulates in the air, often coating or infecting lungs and inducing allergic reactions. Constant exposure to this dust makes it difficult to recover from respiratory illnesses. Accommodations provided for workers were almost always substandard. Water that was used over and over again for bathing led to skin infections and a host of reproductive health problems. Crowded living quarters also meant women had a high exposure to infectious diseases, including colds and influenza. Likewise, food options provided to workers were substandard. Many women complained of general weakness and deteriorating immune systems. Regular headache and back and body pains were the result of restrictive postures and repetitive actions performed during long work hours. Cambodian workers had similar symptoms of back and joint pains, headaches and skin infections.

Generally, the rate of seeing a doctor for a health problem was low. Awareness of reproductive health issues, and in particular, contraception and STIs, varied among the three groups in qualitative interviews. In the Cambodian group, awareness of both contraceptive methods and STIs was directly related to whether the participant had been outreached by the local AIDS NGO around the research site. In the locations used to reach Lao migrants, there was no such organization working and women knew significantly less about related issues. Factory workers in the Burmese group benefited the most from local health organizations, as many of them had been through trainings and, therefore, were more aware of a range of contraceptive options and STI risks. Additionally, these same health organizations distributed condoms and oral contraceptives through factory outreach campaigns, which directly influenced Burmese participants' ease of access to these contraceptives. In all three groups there was a high incidence of women starting with either oral or injectible contraceptives and stopping quite quickly due to side effects. All

three groups purchased oral contraceptives either from a shop (not necessarily a pharmacy) or from NGOs distributing them free.

The rate of condom use was low. The reason provided by the participants was the trust they had in their husbands. Additionally, it was reported that male partners and participants themselves perceived condoms as being for use between men and sex workers rather than for long-term partners. Though some women reported being infected with STI by their husband, this did not influence their decision of not using condoms.

More than half the women who participated in the qualitative phase reported reproductive health problems and having symptoms that fell into the category of vaginal infections and pelvic inflammatory diseases. Women identified their living and working conditions as the cause of these infections. These problems were also linked to the absence of safe sex practices. The findings in this sector signaled raising awareness of contraceptive use and safe sex among workers. As safe sex practices are linked to women's self-esteem, it is important to enhance knowledge and the sense of responsibility of male migrants. Improving work and living conditions is an important factor contributing to the physical, mental and reproductive health of migrant factory workers. The responsible agencies must advocate for this to be placed on the labor protection agenda and the state health care program.

Herbal medicines and traditional practices are commonly used by female factory workers because of their relatively easy availability. The women felt more comfortable speaking about health problems (especially those related to sexual /reproductive health) to the local healers in their own language. Since the local self-help system is popular among factory workers of different national groups, it is important to document the different traditional healing methods and herbal medicines. This would not only enhance traditional healing practices, particularly in the area of reproductive health care, where women own the knowledge, it would also serve to complement scientific medical knowledge.

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CHAPTER 4

Sex Workers

In the qualitative phase of the study, the goal was to interview 60 sex workers who work in Thailand but are migrants from Laos, Burma and Cambodia. Twenty women of each nationality were to be interviewed. In the quantitative phase, those numbers were to be expanded to 600 participants, with the aim of surveying 200 sex workers from each country. In both phases of the study, Lao sex workers were significantly difficult to access because of political events (see: Limitations of the Study – Current Events) that were happening during the research period. Other factors contributing to decreased accessibility were the absence of a strong NGO contact working with this population and also the fact that many Lao migrants succeed in passing off as Thai nationals. Thus, the goal of interviewing 60 sex workers was retained by incorporating 23 Thai women into the study as well. The Thai participants were internal migrants within Thailand, and had moved from rural northeastern areas to urban Central Thailand. They were accessed in the same research sites as Lao and Cambodian participants and often shared similar working, living and migrating conditions. In the quantitative phase (Phase II), Thai participants were not surveyed, as they were not part of the original target populations, though the target number of participants was reduced substantially (only 52 Lao sex workers could be surveyed). Among Burmese and Cambodian sex workers, the numbers surveyed were higher, at 180 and 193 respectively.

In this chapter, qualitative and quantitative responses from sex worker participants are examined. The chapter also provides a detail of the general background characteristics of the participants, and of their geographical and occupational mobility and their current working and living conditions, including a section on perceptions of the best and worst aspects of being a sex worker. Responses to health issues and access to health care will be discussed with particular emphasis on reproductive health concerns, STI rates and safer sex practices. In the final section, participants' ideas about their future will be explored.

4.1 Age, Education and Marital Status of Migrant Sex Workers

The majority of the interviews with sex workers took place outside of their workplace, while many of the quantitative surveys were conducted in work establishments during rest time or in the absence of clients. The type of workplace through which researchers accessed sex workers was largely dependant on the research site, and thus her nationality. Researchers tended to access Burmese sex workers through brothels and karaoke bars. To a lesser extent, hotels where

independent workers worked and lived were also used. Lao workers were accessed through karaoke bars, Thai women exclusively through massage parlors, and Cambodian women through both bars and brothels. These of course are not the only places sex workers of these national groups work. Before the interview process, women were approached at their workplace but were interviewed at a researcher's home or in another place. The survey was administered to Lao women exclusively at the karaoke bars, while it was administered to Burmese women at brothels (42%) and karaoke bars (25%) or another area besides the workplace (an STI clinic – 33%). For Cambodian women, researchers administered the survey primarily in karaoke bars (49%), brothels (36%) and the Bangkok IDC (15%).

Table 4.1: Number of quantitative participants vis-à-vis place of interview

Nationality	Karaoke	Brothel	Other places
Burmese (180)	46 25%	75 42%	59 33%
Lao (52)	52 100%	0 0%	0 0%
Cambodian (193)	95 49%	70 35%	28 15%

Although every effort was made to keep both interviews and surveys private, researchers were not always able to maintain a closed environment. Generally, interviews were almost always private, but surveys were sometimes conducted in public spaces (workplace or a shared residence). The possibility of people overhearing undoubtedly affected responses, even though researchers tried to ask about sensitive subjects (working conditions, treatment by clients and employer, and reproductive health) while no one else was around.

Table 4.2: Details of participants in qualitative phase

Research Site	Nationality	Age group			Marital status				Literacy	
		15-20	21-29	30-50	S	M	W	D	L	NL
North Thailand (Tak Province)	Burmese (20)	8	7	5	11	3	-	6	9	11
East and Central Thailand	Cambodian (14)	4	10	-	4	2	2	6	14	-
	Lao (3)	3	-	-	3	-	-	-	1	2
	Thai (23)	10	5	8	6	2	1	14	21	2
	Total (60)	25	22	13	24	7	3	26	45	15

Generally, interviewed sex workers from all national groups tended to be young, usually under thirty. However, their educational backgrounds varied greatly as per nationality. The sex workers who were single and divorced were nearly equal in number (24 and 26 respectively). All three of the Lao participants who were interviewed were under 21 years of age and single, though only one out of three was literate. Eight out of twenty Burmese participants were under 21, while seven were 21-29, and five were over thirty. Most Burmese sex workers were unmarried, with 11 reporting that they were single and 6 divorced. This group had the highest presence of married participants (three women). Eleven out of twenty Burmese participants were illiterate. All 14 Cambodian participants were under 30, with four being under 21 years of age. There were two married women in the group, while four were single, two were widowed and six were divorced. All the Cambodian participants were literate. Literacy rates were also high in the Thai group, with 21 out of 23 participants reporting that they were literate. This group was the most evenly distributed in terms of ages – ten were under 21, five were between 21-29 and eight were over 30. This group had the highest incidence of divorce – 14 out of 23 participants. Of the remaining, six were single, two were married and one was widowed.

Table 4.3: Details of participants in quantitative phase

Nationality	Age Group			Marital Status				Literacy	
	Under 21	21-29	30 and Over	Single	Married w/ H	MS	W/D	L	NL
Lao (52)	29 55%	18 34%	5 11%	57.6 % 30	1 2%	1 2%	20 38%	47 90%	5 10%
Burmese (180)	61 34%	99 55%	20 11%	58 32%	28 15%	30 17%	64 36 %	154 86%	26 14%
Cambodian (193)	99 51%	85 44%	9 5%	94 49%	2 1%	7 4%	90 46%	130 67%	63 33%
Total (425)	189 44%	202 47%	36 9%	182 43%	31 7.%	38 9%	174 41%	331 78%	94 22%

Key:
Marital Status: S-single; M-married; Married w/H- married and living with husband; MS-married but geographically separated from husband; W-widowed; D-divorced
Education: L-literate; NL-illiterate

In the quantitative group, there was a similar tendency to be single or widowed. However, there was greater distribution of ages and higher literacy rates. Fifty-five percent of Lao participants were under the age of 21, while an additional 34% were in the ages of 21-30. In this group alone,

57% were single and 38% either widowed or divorced. Lao quantitative participants had a higher literacy rate than the Lao qualitative group, with 90% surveyed participants reporting they were literate. Burmese participants had the highest number of women over 21, with 55% in the age group of 21-29 and another 11% reporting to be 30 or older. This group also had the highest percentage of married participants – 32%, with half of those living geographically separated from their husbands, while the other half living with their husbands. Thirty-two percent reported being single and 35% reported being either widowed or divorced. Eighty-six percent of Burmese participants were literate in contrast to 67% of Cambodian participants who had the lowest percentage of literacy among the three groups. Fifty-one percent of Cambodian participants were under 21, while 44% were between the ages of 21-29. Most Cambodian women surveyed reported being alone – 49% single and 46% either widowed or divorced.

To a sex worker, her ability to communicate in the Thai language is often more important than her formal education level. Her communication ability directly impacts on her comfort level in general. Lao participants had the highest rating for having basic ability in Thai (67%). Among Cambodian participants, 32% had no Thai language skills, whereas 19% Burmese women were not able to speak Thai. While these numbers may appear minimal, in all three groups, less than half of the women considered themselves fluent or being able to read in Thai. Yet, almost all of them had Thai clients in their sex work and needed to use Thai or a translator if they sought health care in Thailand. The importance of this is supported by findings from the qualitative phase that indicates how a migrant woman's lack of Thai language skills directly reduces her ability to access health care and information and negotiate for wages and fair treatment.

Table 4.4: Ability to communicate in the local language

Nationality	Don't know Thai	Basic Thai	Fluent/can read basic Thai
Laos (52)	5 10%	35 67%	12 23%
Burmese (180)	34 19%	71 39%	75 42%
Cambodian (193)	62 32%	101 52%	30 16%
Total (425)	101 24%	207 49%	117 27%

4.2 Mobility History

Participants in both the qualitative and quantitative phases decided to migrate to Thailand for a variety of reasons. Some women were escaping economic problems due to family debt or a lack of work in the rural areas from where they came. Others had family members and friends who had migrated beforehand and encouraged them to make the move as well. Some women were simply adventurous or curious and wanted to know more about Thailand and the options available to them across the border. Women entered sex work after moving to Thailand for a variety of reasons: friends who were already sex workers had encouraged them, they didn't like other work options, or they wanted to increase their wages. In these sections, women's patterns of mobility – from their homes to Thailand as well as between occupational sectors – will be examined.

4.2.1 Geographical Mobility Patterns

> *Aki, at 16 years, was lured by her relative to get a job in Mae Sot. Her relative sold her to a brothel owner and she was forced to work there for 2 months. She then returned home. At home she found that her parents got sick often and did not have money for treatment. So she took the decision to return to sex work again.*
>
> *Burmese worker, 19 years old, currently working in a brothel*

Participants moved from their country of origin through a variety of ways. With friends, family members or agents, they often moved out of the area they had originally called home, working their way to border towns to cross into Thailand. In many cases, migration agents were used and proved helpful in guiding participants across restrictive borders or through unmarked routes. In some situations, agent prices were widely known and they gave little assistance to the migrant once they were in the new location. Other migration agents worked in abusive ways, exploiting migrants financially, deceiving migrants about the working conditions they had arranged for them, forcing migrants to do things or to go to places they had no intention of going, holding migrants captive and selling them to an employer. Another risk in the process of migration was encountering physical or sexual abuse from other members in the migrating group. This particularly occurred to those who traveled in groups across isolated areas (forests or backcountry) to avoid checkpoints along public roads.

Burmese qualitative participants tended to migrate at a young age, with 16 out of 20 having been 20 years old or younger at the time of migration. Women came from both poor and middle-class backgrounds, though in several cases, women described themselves as middle-class when their families did not have debts, owned a small piece of land and/or had a couple of luxury items (such as a refrigerator or television). This did not mean that they or their families were earning

sizeable incomes or did not have to do manual labor. Those from more impoverished backgrounds often had family debt, were divorced, or had a parent who was sick or dead, resulting in loss of income. While women migrating from Burma were clearly influenced by the political unrest and oppression in Burma,[31] this study has not examined the particularities of the situation in an in-depth manner.[32]

> *Lui Lui's parents divorced when she was a small child. Her mother came to work in Thailand, leaving her and her younger sibling alone at home. At that time she was 7 and her sibling was 3. An aunt who lived nearby took care of them and the mother sent money every month. After grade four, she had to leave school because her mother stopped sending money. Then she went to Mywaddy to work in her uncle's house. When her mother came to visit her after a year, she took her to work in Mae Sot. Her mother brought her on a boat across the Moei River. She got her a pass from Immigration and they took a bus into Mae Sot. She went to the clothing factory where her mother worked and had to wait for a week before getting a job in the ironing department.*
>
> *Burmese worker, 17 years old, currently working in a brothel*

Burmese migrant workers often move from small villages or towns to Burma's capital, Rangoon, or border towns like Mywaddy before crossing into Thailand. Migrants then follow well-used routes connecting with public buses and hoping to meet travel companions. The people that they accompany are strangers, friends, family members or brokers and are not necessarily known beforehand. At the border immigration checkpoint, they usually buy a green day-pass for 20 baht (USD .50)[33] that allows them to go into the township of Mae Sot with the restriction that they must be back on the Burmese side of the border before 5 pm. Many reported overstaying the pass validity, while others did not pass through the checkpoint in the first place and instead crossed through the Moei River that separates Thailand from Burma. All of the Burmese sex workers were illegally residing in Thailand, unregistered and without work permits.

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[31] "A large number of undocumented migrant workers from Burma come into Thailand for a range of economic reasons, but a greater number. . . .initially flee Burma to escape the repressive policies and practices of the SPDC [State Peace and Development Council] military regime. In many cases, it is impossible to make a simple distinction between the economic hardships faced by the civilians from Burma and the human rights violations suffered throughout the country. Many people from Burma who have fled to Thailand do not have enough to eat, due in part to the widespread practice of forced labour, forced relocation and other forms of human rights violations. Such people perform work for the military under conditions so harsh that they are prevented from earning a living." (Human Rights Documentation Unit, et al. 2000, 24-25)

[32] For information on the political situation in Burma and how it influences current migration, see: Human Rights Documentation Unit & Burmese Women's Union. *Cycle of Suffering: A report on the situation of migrant women workers from Burma in Thailand*. Bangkok, Thailand, 2000.

[33] Conversions from Thai baht to US dollars are based on $1 = 40 baht, the rate at the start of the project.

Noi wanted to see Thailand and her father also wanted her to earn money to help the family. An agent in the village regularly sends people to Thailand and arranges their travel as far as across the border. Her father paid about 3,000 baht (USD 75) in travel costs for her. She was driven almost the entire way.

Cambodian worker, 20 years old, currently working in a karaoke bar

Sex workers from Cambodia also tended to be young at the time of their first migration, with over 50% of those interviewed having migrated when they were under 20 years old. In this group, women were often escaping a troubled situation at home, including economic hardship, recent divorce or death in the family. Qualitative Cambodian participants migrated with family members or with an agent/broker. Women commonly paid around 3,000 baht (USD 75) to agents to take them from Cambodia into Thailand. (There were more cases of Cambodian women facing abuses like sexual assault from members of the group they migrated with than women of other national groups). Participants attributed this to the long and isolated migration routes they took to avoid checkpoints. Some of the Cambodian sex workers surveyed in the quantitative phase crossed the Aranya Prathet/Poipet border, an area busy with commerce and trades-people going back and forth on a daily basis. Cambodians did not need to have documentation to cross the border, but were required to pay 20 baht and to be back on the Cambodian side before 8 pm. However, there were restrictions as to how far they could travel, with checkpoints on the roads leading away from the township.

All Thai sex worker participants had migrated from the rural north and northeastern Thai villages to the southeast town of Rayong. Similarities existed between their patterns of movement and those of other participants crossing international borders. The Thai sex workers generally came from poor economic backgrounds but had relatives or friends who had previously migrated to other areas in Thailand. Almost all the women either came with or followed a relative who had previously migrated. In addition, 4 out of 23 women migrated soon after their divorce that left them in an economically disadvantaged position. As all these women were Thai nationals, they resided legally in Thailand.

At the age of 13, Nok moved from Sawannakhet to Thailand. Her parent paid 3,500 baht to the broker. In Bangkok she was lured and forced to work in a massage parlor as a sex worker. When she refused, she was confined and beaten by the manager. Some clients forced her to have sex and abused her badly. A month later she escaped from the place with the help of a client. He brought Nok to Mahchai and got her a job in a karaoke bar. Nok later decided to do sex work by choice.

Lao worker, 19 years old, working in a karaoke bar

The three Lao sex workers who were interviewed came with the assistance of a migration agent and had paid around 3,500 baht (USD 87.50), the same amount as those who had migrated with agents from Cambodia. All three women were under 20 years of age when they moved, were unmarried and worked illegally without registering or acquiring work permits. During the quantitative phase, the areas used to reach Lao women were expanded to include two northeastern border sites (Chong Mek and Khong Jiam) where migrants passed through the border without needing documents or paying a crossing fee. However, they did need to be back in Lao before 6 pm, when the police start checking people on the street for Thai identity cards. They risked arrest if they did not have proof that they were Thai. In reality, paying bribes was also a possible alternative. It was common knowledge in the area that migrants needed to stay indoors after 6 pm. Those in the quantitative group who used agents were either first time migrants or were trying to get into other, more restricted, areas of Thailand (e.g. Central Thailand).

Table 4.5: Migration status in qualitative phase

Research Site	Nationality	Migrant status		Migrated with				Age at migration	
		L	IL	S	F	FM	BO	15-20	21+
North Thailand (Tak Province)	Burmese (20)	-	20	2	6	8	4	16	4
East and Central Thailand	Cambodia (14)	1	13	-	-	6	8	8	6
	Lao (3)	-	3	-	-	-	3	3	-
	Thai (23)	23	-	13	4	2	3	16	7
	Total (60)	24	36	15	10	16	18	43	17

Key: Migrant Status: L-legal; NL-illegal (without work permit or registration)
Migrated With: S-self; F-friend; FM-family member; BO-broker or agent

Because migration from all three countries to Thailand has been going on for several generations, many workers had an idea of specific aspects of the process including the type of work available, the location itself and the wages they would earn. This was most clear for factory workers. Sex workers knew details about their future occupation only if they had done sex work before or had close connections with other migrant sex workers. In several cases, sex workers had migrated with the intention of doing other types of work but ended up not liking that type of work, as it was either strenuous and did not pay enough or there were no jobs available at that time.

While sex workers were more mobile than other migrant workers in the study, only a few of them reported doing sex work in another location besides the research site. Only 6% of the surveyed participants reported having worked as sex workers elsewhere. Most Burmese migrants who had

worked elsewhere had worked in Bangkok, while Cambodian sex workers tended to have worked in Sakaew Province near the Thai border. None of the Lao participants had done sex work in another area.

4.2.2 Occupational Mobility

Sixty percent of the quantitative participants began sex work between the ages of 15 and 20. Burmese and Lao sex workers tended to start at older ages with over 40% of both groups reporting to have started at over 20 years of age. Twenty-seven percent Cambodian sex workers started over the age of 20.

Table 4.6: Age at start of sex work in quantitative phase

Nationality	Less than 15 yrs.	15-17 yrs.	18-20 yrs.	More than 20 yrs.
Lao (52)	0 0%	6 11%	25 48%	21 40%
Burmese (180)	4 2%	37 21%	58 32%	81 45%
Cambodian (193)	9 5%9	69 36%	62 32%	53 27%
Total (424)	13 3%	112 26%	144 34%	155 37%

Reasons for beginning sex work differed among national groups, though the primary reason for both Lao and Burmese workers was economic (over 70% of both groups), while the most cited reason for Cambodian workers was the non-availability of other options at that time (28%), as opposed to 6% for economic reasons. Alarmingly, 13% of Burmese and 40% of Cambodian workers both cited being 'lured into sex work'[34] as their primary motivation for starting sex work.

This was supported by the qualitative findings. All three nationalities responded that they were working contentedly at the time of interview. However, in the qualitative study, 16 out of 37 of non-Thai participants had been lured or forced into sex work – 12 out of 20 Burmese, 3 out of 14 Cambodian and 1 out of 3 Lao women. Of these, 2 participants reported starting sex work at 15 and 16 years.

[34] 'Lured into sex work' can refer to a variety of situations – being forced by a migration agent or employer or being strongly pressured by family members to begin sex work. Although this could indicate a situation of being trafficked, the question did not specify whether their migration also contained elements of deception or force.

Table 4.7: Reason for doing sex work

Main reason	Lao (52)	Burmese (180)	Cambodian (193)
Economic pressure	39 75%	142 79%	39 20%
Lured by agent/friend /relative	0 0%	24 13%	77 40%
Forced by family member	0 0 %	3 2%	11 6%
Others, escaped from problem at home (husband, stepfather, stepmother)	13 25%	11 6 %	66 34%

Most participants began to do sex work in either a brothel or a bar catering to Thai men. All of the Lao sex workers surveyed started in a bar. Thirty-three percent of Burmese workers began working at bars, 58% started to do sex work at brothels, 8% started as freelance/street workers. Forty-nine percent of Cambodian workers began their work in brothels, 44% in bars and 4% in massage parlors.

At the time of survey, locations had changed slightly, with 49% of Cambodian and 58% of Burmese participants reporting to work in brothels. These brothels were generally similar: modest houses that sometimes additionally sold beer, with small rooms available for services. Clients tend to be in and out of the brothel fairly quickly. Ninety-three percent Lao women reported working in a bar currently, and 33% Burmese and 44% Cambodian participants reported the same. Most of these were karaoke bars, a common cover business for commercial sex establishments in Thailand. Karaoke bars in all locations had chairs, tables, karaoke machines and served snacks and drinks. Men tended to spend considerable time socializing prior to deciding whether they would arrange for sexual services. In bars, women would actively flirt with their customers, encouraging them to arrange for a service or buy drinks for both, from which they would collect a commission. There were often one or two private rooms for services, but not many as to avoid appearing like a brothel. This meant that women often needed to leave the vicinity of the bar itself and the safety of the workplace to service clients. Women usually had a sleeping arrangement in the bar itself often sharing one big room or the small rooms located in the bar. Eleven percent Burmese and 8% Cambodian participants reported working as freelance sex workers, many of them living and working in modest hotels. Hotels where freelance sex workers lived and worked tended to have small rooms that they sometimes shared with a friend, another sex worker or a family member.

Table 4.8: Working establishment at the time of interview

Working establishment	Bar/Karaoke	Brothel	Massage parlor	Escort	Freelance / arrange own work
Lao	51 98%	1 2%	0 0%	0 0%	0 0%
Burmese	66 37%	91 51%	3 2%	0% 0	10 11%
Cambodian	82 42%	87 45%	10 5%	0 0%	15 8%

Occupational History

> *Mai-Mai's first job after crossing the Moei River into Thailand was at a karaoke bar. Her duties were to serve beer and sit and chat with customers. Other girls had sex with the customers, but she didn't. Five months into the job, she met a Thai man and married him. They were together for two years. About a month after they broke up, she went back to Burma, stayed at home for over a month and then came to Mae Sot. She stayed there with a friend waiting for a job at a sewing factory. After being jobless for 20 days, she decided to take up sex work on her friend's suggestion.*
>
> *Burmese sex worker, 28 years old*

During the time of the qualitative interviews, none of the participants were in their first jobs and over half had done sex work at other establishments. Among the women interviewed, 18 out of 60 had worked as sex workers before their current employment and 12 women had done domestic work. Among the Thai migrant sex workers interviewed, nine had done sex work at another location, five had done factory work and four had done domestic work in the past. Most notably, Burmese women had previously done domestic and factory work, while Lao women had done factory and sales work and Cambodian women had worked in sales and karaoke bars.[35]

Table 4.9: Other types of job before sex work in quantitative phase

Other kinds of work held	Burmese (107 of 180)	Laos (16 of 52)	Cambodian (66 of 193)
Domestic Work	54	3	5
Factory work	44	5	0

[35] While in many cases working in karaoke bars is associated with sex work, Cambodian women said they had worked in karaoke bars as waitresses or singers but did not do sex work.

Sales (food, etc.)	8	5	17
Beauty salon	0	0	6
Construction	1	0	10
Farm	0	0	4
Fishery related	0	0	10
Karaoke bar	0	2	7
Others*	0	1	7
Total	107	16	66

*Such as working in laundry, sewing or childcare

Table 4.10: Occupational Mobility of Non-Thai qualitative participants

Combined Nationalities: Lao (3) Burmese (20) Cambodian (14)	Other work done besides current job	Number of Workers
	Sex work / never had other job	18
	Domestic work	12
	Factory work	4
	Other types of work**	3
Total		37

*Includes four cases of workers who returned to sex work after doing a different type of work.
**Includes construction and shop keeping

Conditions and Relationships

The working and living conditions of sex workers varied depending on the site and type of establishment in which the women worked. In both brothels and bars, most of the workers associated with the place resided there and paid boarding costs. Food was generally made available for women so they didn't have to leave the vicinity, a condition that was particularly valuable when women feared arrest. Medical assistance was generally not offered to sex workers by their employers, except transportation to STI clinics, general painkillers and condoms at the work establishment. The participants who lived in their brothel or bar tended to start work at 4 or 5 pm and finish around 1:00 am, though servicing clients could continue depending on when they showed up. Many women complained that they lacked sleep, as they could rest only when clients were not present. Among Burmese participants in the qualitative phase, most worked in brothels or bars and lived in the same place they worked. These conditions were supported by quantitative findings, in which 87% of Burmese participants worked in either a brothel or bar and 90% of the group lived in their workplace. Generally, women earned half of the fees their clients were charged. The fee was dependent on whether the client wanted her services for a short duration (usually an hour) or for an entire night. For a short service, clients tended to pay around 300 baht (USD 7.50) and for the entire night, they paid between 800-1000 baht (USD 20-25). Women reported earning 3,500 to 7,000 baht (USD 87.50 to 175) per month based on serving two to four

clients per night, except for the nights when they were menstruating or did not work for other reasons. Workers who lived within their work establishment had part of their wages deducted for living accommodations, which generally included room/utilities, food and a mandatory charge for bribing local police.[36] Costs for accommodations typically ranged from 1,000-1,600 baht (USD 25-40) per month and included a shared room with many other women. Several participants also reported that condoms were part of the living accommodation package provided to them.

Several of the Cambodian qualitative participants made approximately the same wages as the Burmese group, though only a third of them lived in the establishment where they worked. Many women worked in karaoke bars that often did not provide separate rooms for the women to live in or service clients. In these cases, clients typically paid an extra 200 baht (USD 5) 'off' fee to take a worker off the premises during her working hours or waited until she was done with work and thus avoided paying the extra fee. Typical working hours at the karaoke bars were from 4 pm till 2 am or depending on when clients either showed up or left. In some cases, women worked in restaurants or shops where it was known in the community that sex workers were available after closing hours. Women reported servicing two to four clients per night and charging over 1000 baht (USD 25) for a whole night. Among the quantitative participants, 8% of Cambodian sex workers had done other work in order to supplement this type of seasonal sex work.[37] As the research sites for Cambodian sex workers expanded during the quantitative phase, the number of participants living in their workplace significantly increased to 92%, while the number of women working in bars decreased to 42%.

Among Lao workers in the qualitative phase, women also tended to work in karaoke bars but lived within their work establishment. Two of the three women began their work doing other jobs in the same bars, such as reception work and cooking. In the case of the third woman, she had been sold to the bar owner and worked without pay in order to pay back the manager's debt for buying her. At the time of the interview, however, she had been arrested and was awaiting

[36] Police bribes were an overhead cost in most, if not all, of the commercial sex establishments we came into contact with. Bribes included monetary fees, as well as alcohol and services by sex workers for reduced cost or for free. In a conversation between a Mae Sot brothel manager and a researcher, the manager complained that two police personnel had just been in, drank a bottle of her most expensive whisky and were presently out with two of her employees. "Everything for free! We cannot charge them!" Regular bribes did not, however, seem to stop police from using their authority to raid or close down establishments on occasion.

[37] Seventeen Cambodian sex workers had side jobs. Six were in fishery-related factory work, five in beauty salons and two women in sales.

deportation at the Bangkok IDC. In the quantitative phases, 94% of Lao participants reported living in their workplace and almost exclusively working in bars.

> *Ratree migrated to Thailand because of poverty. She came with a broker who brought her through Ubon Ratchathani Province and sold her to another Thai broker. After a week, she was sent to a place where they trained her for body massage before sending her to work in a massage parlor. Later she was forced to do sex work. The employer told her to work in order to pay back the debt of 10,000 baht. She had no idea about the debt. She worked for one and half months and received 2-4 clients a night. She was arrested while working in the massage parlor.*
>
> *19-year-old Lao sex worker at the IDC*

Interviewed Thai participants also worked in karaoke bars, and a majority lived at the worksite. Wages for this group were significantly higher than for the other national groups, with several women earning 10,000 baht (USD 250) per month. This group was at a clear advantage in negotiating wages and working conditions, as all the women spoke Thai and were not at risk of deportation. Yet, this did not result in working conditions that were free of hardship or exploitation. Many women reported not having leave or time off, except when there were no clients or the police had asked the manager to temporarily close the bar.

Relationship with Employer

Employers who provided their sex workers with the necessary protection could also be the source of exploitation and abuse or a mix of both. How participants felt about their work, their working conditions and their employers were all highly dependent on how supported they felt in their workplace. One of the most significant factors of support was their employer's ability to negotiate with troublesome clients. Some participants reported that they could decline servicing clients who refused to wear condoms or acted in harmful ways. Other participants mentioned that they were required to service a client regardless of behavior. Another example of employer support was the provision of transportation for workers when needed, such as visits to the STI clinics or to outside locations for work. But the line between employer-protection and employer-control is always a thin one. For instance, women reported the importance of being able to live close to their workplaces to avoid trouble from the police or risk arrest while traveling in the town. However, employers also used this proximity to exercise control, as they had access to their workers at all times. In these situations, workers can become more dependent on the employer resulting in a loss of self-confidence, and would have a limited understanding of the local area and outside

resources available to them. Employers can also have more control over deductions from the workers' wages for essentials such as rent, food and other necessities provided by them.

Occupational Violence and Abuse

The above examples of employer-control are illustrative of how employers can inflict violence, and abuse the human rights of migrant sex workers on a daily basis. Being forced to work more than eight hours a day or being available for 24 hours, being threatened or mistreated by employers and managers and being forced to do specific tasks at work that are harmful (e.g. working without condom or providing service to a client who is suspected to be unclean) – are some of the other forms of violence and control. Sex workers also face the risk of being abused by clients in an occupational sector that has no legal protections for them due to their illegal status and unprotected occupation. They have no recourse in such abusive situations or even a safe place to go to for help. To report violence from clients to local authorities is to risk being arrested or mistreated by the police for being a sex worker or being deported as an undocumented immigrant.

Table 4.11: Quantitative participants reporting violence

Nationality	Experienced abuses and assault	Never experienced abuse and assault
Lao (52)	11 21%	41 79%
Burmese (180)	106 59%	74 41%
Cambodian (193)	60 31%	133 69%
Total (425)	177 42%	248 58%

In researchers' conversations with sex workers, participants were asked to discuss the types of abuse they faced from employers, clients, colleagues and the police or local authorities. Women reported numerous painful stories of abuse. With regard to violence and abuse, patterns and trends were particular to national groups. For Thai women, sexual harassment and physical abuse from clients were the two most often experienced forms of violence. Five out of twenty-three women reported cases of rape, clients forcibly removing or refusing to wear condoms, and pain or injury caused by intercourse with clients who have objects inserted into their penises or use penis-enlarging drugs. Cambodian sex workers also reported this last behavior, which is said to increase male pleasure and the duration of an erection, but is very painful for the woman. This practice led

to condoms not fitting properly or breaking during intercourse.[38] For women who work in bars, sexual harassment can occur even before customers have arranged and paid for sex work. Burmese women reported a high incidence of harassment and insults from both clients and police in terms of being forced to work long hours without leave and to service clients whom they did not want to serve. Cambodian women also reported that over a third of them had suffered cases of harassment and insults and had been physically abused by clients.

Table 4.12: Qualitative participants reporting violence

Nationality	Lao (3)	Burmese (20)	Cambodian (14)	Thai (23)
Sexual harassment	1	5	5	7
Verbal insult	1	13	2	5
Rape	0	1	3	5
Gang rape	1	4	0	0
Beaten	1	4	5	6
Forced to remove condom	0	0	2	5
Aggressive sex	0	0	1	5
Insert object in penis	0	0	0	5

* Women could give more than one response.

The quantitative results showed clearer patterns and trends even if the responses were limited by the close-ended questions. However, participants may have disclosed less sensitive information than in the one-on-one interviews where researchers and participants often formed a stronger intimate and trusting relationship. Among Lao women, cases of violence and abuse were reported as fairly low. No participant reported abuse by employer or manager. Six women reported client abuse (namely cases of rapes) and four reported cases of police threatening them. Among Burmese women, cases of abuse were much higher, though reports of abuse by employers or managers were low (six women). Among Burmese participants, 61 women reported suffering

[38] Women reported having lacerations, bruises and tearing along vaginal walls as a result of having sex with clients who had inserted pebbles, bits of plastic, toothpicks and other objects through and under the foreskin of the penis. As noted in *Tangled Nets* (p 12): "To pass the time while on the boats, men indulge in bonding activities that also pose risks of HIV transmission. Although tattooing is sometimes done using the same jagged needles repeatedly without any sterilization, a more alarming activity is penis 'enhancement', where men insert marbles or inject hair oil under the foreskin to enlarge their penises. Not only does the sharing of needles and instruments put fishermen at risk, these enlargements cause condoms to break easily and can rip the vaginal walls of their partners." *Tangled Nets: The vulnerability of migrant fishermen and related populations in Thailand*, Raks Thai Foundation, *2003*.

abuses from clients – 40 cases of rape, 12 cases of clients threatening the workers, and 6 cases of clients being physically abusive. Twenty-seven women reported police abuse cases with most of them being rapes or threats. Ten women reported facing violence from their colleagues – primarily being raped and also being physically abused and threatened. Among Cambodian workers, the numbers were again lower – ten women reported being abused by employers or managers, with the majority of those cases being rape. Thirteen out of 193 Cambodian sex workers reported cases of abuse from clients, with the majority of those also being rape; thirty-two women reported facing violence from police, all of those being either physical abuse or rape.

Table 4.13: Quantitative participants reporting employer violence

Nationality	Beaten	Raped	Threatened	Other forms of violence	Total
Lao	0	0	0	0	0
Burmese	1	0	3	2	6
Cambodian	2	5	1	2	10
Total	3	5	4	4	16

Table 4.14: **Quantitative participants reporting client violence**

Nationality	Beaten	Raped	Threatened	Other forms of violence	Total
Lao	0	2	0	4	6
Burmese	6	40	12	3	61
Cambodian	4	9	0	0	13
Total	10	51	12	7	80

Table 4.15: Quantitative participants reporting police violence

Nationality	Beaten	Raped	Threatened	Other forms of violence	Total
Lao	0	0	4	0	4
Burmese	2	10	15	0	27
Cambodian	16	16	0	0	32
Total	18	26	19	0	63

Table 4.16: Quantitative participants reporting violence by colleagues (security guard, manager)

Nationality	Beaten	Raped	Threatened	Other forms of violence	Total
Lao	0	0	0	0	0
Burmese	2	4	3	1	10
Cambodian	1	1	0	0	2
Total	3	5	3	1	12

To take into account both the risks and benefits of sex work, participants were also asked their opinions about the best and worst aspects of the occupation. Clients who are mean, drunk and violent with women were rated as the worst aspects of sex work by 52% of the participants. Among Lao workers, a majority (38%) reported that there was nothing bad about being a sex worker. Among Burmese participants, 22% reported that the second worst thing was the physical and mental difficulty of the job. For 31% Cambodian workers, the second worst thing was facing the demeaning attitude of the police and the local population. Income was rated to be the best aspect of sex work by both Lao and Burmese workers. Lao workers cited job safety as the second best thing, whereas for Burmese workers it was nice colleagues (other sex workers). For Cambodian workers, the best aspect was a friendly client, followed closely by income.

Table 4.17: The best thing about sex work

Nationality	Lao (52)	Burmese (180)	Cambodian (193)	Total (425)
Money/ income	31 60%	167 93%	73 38%	271 64%
Friendly client	0 0%	1 1%	87 45%	89 21%
Nice colleagues	7 13%	4 2%	15 8%	26 6%
Have a safe place to stay	13 25%	3 2%	9 5%	25 6%
Nothing good	1 2%	4 2%	9 5%	14 3%

Table 4.18: The worst thing about sex work

Nationality	Lao	Burmese	Cambodian	Total
Nasty/drunken/an aggressive client	11 21%	115 64%	97 50%	220 52%
Bad attitude from police and local people	4 8%	18 10%	59 31%	81 19%
Physical & mental difficulties of the work	6 12%	40 22%	25 13%	71 17%
Other	11 21%	7 4%	11 6%	29 7%
Nothing bad	20 38%	0 0%	1 0%	21 5%

4. 3 General, Occupational and Reproductive Health

Throughout the study, women often discussed poor health symptoms due to their long working hours, lack of leave, and substandard living conditions. Such conditions bring about fatigue and a general weakening of their health, amplified by sporadic access to medical attention. These circumstances, coupled with a lack of knowledge of health and prevention skills, provide a fertile ground for occupational and reproductive health risks. In the following sections, the study focuses on participants' general health status, reproductive health, and their awareness/skills to protect themselves from reproductive health risks.

4. 3.1 General Health

In the quantitative survey, participants were asked about their health and their knowledge of health. When asked how they rated their state of health, in all three groups, the majority reported that it was either very good or fairly good. Very few women stated that their health was either poor or very poor.

Table 4.19: State of health in quantitative phase

Nationality	Very /fairly good	Average	Rather poor	Very poor	Total
Lao	41	9	2	0	52
Burmese	130	43	7	0	180
Cambodian	75	110	8	0	193
Total	246	162	17	0	425

When asked whether they thought they had sufficient knowledge about their health and body systems to take care of themselves adequately, responses varied across national groups.

Table 4.20: Knowledge of health and body systems for self-care in quantitative phase

Nationality	Yes, I know enough	No, I don't know enough	Not sure
Lao (52)	14 27%	22 42%	16 31%
Burmese (180)	166 92%	10 6%	4 2%
Cambodian (193)	27 14 %	32 17%	133 69%
Total (425)	207 49%	64 33%	153 36%

In the case of Burmese sex workers, 92% felt that they knew enough about their health and body systems, whereas only 14% Cambodian women felt that way. Twenty-seven percent Lao sex workers felt that they knew enough to take care of themselves, while 31% were unsure. This difference among the groups may be related to the number of health-based education programs and NGO projects in each of the research sites. The site of the Burmese participants (Mae Sot) had more such projects than any other and this trend applies to participants of other occupational sectors as well.

Sixty percent of all surveyed sex workers indicated that they had a health problem at the time of research. Among Lao sex workers, 32% reported having a general health problem currently. Twenty-three percent Lao participants reported that they had regular headaches and 21% reported having back pain. Fifty-four percent Burmese sex workers reported having a current health problem. Among specific problems, 18% reported regular headaches, 14% had general weakness of the body, body aches and/or joint pain and 4% reported lower abdominal pain and/or menstrual pain. Seventy-three percent Cambodian sex workers said that they currently had a general health problem, 43% reported regular headaches, 17% reported back pain, 14% reported lower abdominal pain and/or menstrual pain and 12% reported general weakness of the body, body aches and/or joint pain. This was slightly different from the findings in the qualitative phase, in which 21 out of 60 sex workers reported having digestion troubles (acidity, diarrhea and constipation), 19 reported having regular headaches and 18 reported urinary tract infections.

4. 3.2 Occupational Health

Reproductive Health

> *In the first month of my sex work, I didn't know how to use a condom. Good Burmese women don't talk about sex.*
>
> *Burmese worker, 19 years old, lured by her relative*

In both phases of the study, the level of awareness among participants regarding reproductive health issues varied. Some women knew very little, while others had a higher level of awareness as they had been through trainings held by local NGOs or health care institutions. It was important to ask the women on which issues they had received information in the past. In the quantitative phase, approximately 20% said that they had never received any kind of health information, over 50% had received some information on HIV and an additional 26% reported receiving information on other STIs. Forty-two percent of Lao women stated that they had not received any information on health in the past. Burmese sex workers reported having received information on more topics than members of the other groups probably because the site used for research on them had several active NGOs working in the area of health.

With regard to actual reproductive health symptoms being reported, nearly half of the sex workers in the qualitative interviews reported painful periods, heavy and irregular bleeding, absence of menstruation, severe cramps and/or passing of blood clots. These were all categorized as menstrual disorders in the table below. Additionally, 43 out of 60 participants discussed having symptoms that fell into the category of vaginal infections and/or pelvic inflammatory disease (PID), including discolored and foul smelling discharge, pain and severe itching. Several sex workers interviewed reported having severe lower back and abdominal pain during intercourse. A number of these problems are presumably related to an inability to maintain proper vaginal hygiene due to lack of clean water and privacy, or unhealthy methods of stopping blood flow to continue servicing clients. Additional injuries and infections were caused by rough sexual behavior from clients, vaginal intercourse with clients who had objects inserted into their penises, and unsafe sex (sex with clients refusing to wear a condom).

Table 4.21: Reproductive health problems in qualitative phase

Ailment	Burmese (20)	Cambodian (14)	Lao (3)	Thai (23)	Total (60)
Menstrual Disorders	9	5	2	13	29
Vaginal Infections & PID	20	8	-	15	43

Furthermore, many sex workers reported washing themselves vaginally with soap before and after servicing clients and whenever a condom would break. Such frequent washing can disturb the protective microbes in the vagina. It can "decrease the vagina's normal levels of lactobacillus. This has adverse consequences for vulvo-vaginal health, affecting lubrication, the epithelium or vaginal lining, and the normal vaginal flora, which serve a protective function against potential pathogens".

Especially alarming were reports of women washing their vaginas regularly with harsher substances such as toothpaste, rubbing alcohol and nail polish remover. Whenever possible, researchers followed up on their interviews with women who reported to be doing such practices with explanations of why washing with these substances, or so often, was not advisable.

> *I normally do internal washing with liquid, and sometimes when I find the condom broken, I wash more carefully with Dettol (anti-bacterial liquid cleaner).*
>
> *Thai worker, 29 years old, working in Karaoke bar*

> *When I suspect any client, I immediately do internal washing with toothpaste and lots of water. After washing many times, I smear toothpaste in the vagina and leave it until I feel comfortable. I'm afraid of getting an infection.*
>
> *Burmese worker, 19 years old*

> *I smear a lot of toothpaste in the vaginal region to keep me cool and to lessen the pain after serving an aggressive client or a client who takes long for intercourse.*
>
> *Lao worker, 19 years old*

In the quantitative survey, researchers asked questions regarding specific reproductive health problems, focusing on STIs (gonorrhea, syphilis and chlamydia). It is reasonable to assume that reported rates of STIs are lower than actual rates due to the sensitivity and the social stigma associated with the subject matter. Reported rates may also be lower because not all participants were tested when they showed symptoms. It is also a fact that those who have had STI checks do not always know their diagnosis. Researchers began questioning on the topic with a general query regarding whether participants had had STI in the past year. Among Lao and Cambodian participants, affirmative responses were rather low, with 0% and 13% respectively reporting they have had an STI. Almost 20% of both of these groups responded that they didn't know or were unsure if they had ever had an STI. In contrast, 4% of Burmese sex workers reported that they were unsure if they had had an STI. Thirty-seven percent Burmese sex workers said that they had had an STI, while 58% reported they had not. This difference in numbers is clearly linked to certain circumstances affecting the groups, including work establishments and access to health services, which will be discussed later. In answer to questions about particular STIs, responses

were rather insignificant. Burmese participants were the only ones who reported anything statistically relevant, with 34% reporting chlamydia, 30% reporting gonorrhea and 10% reporting syphilis. As noted earlier, this testifies to the availability of STI health services to Burmese migrant sex workers at the research site.

Table 4.22: Reporting STI in past 12 months in quantitative phase

Nationality	Yes	No	Don't know
Lao (52)	0 0%	43 82%	9 17%
Burmese (180)	67 37%	105 58%	8 4%
Cambodian (193)	26 13%	129 47%	37 19%
Total (425)	93 22%	277 65%	54 13%

Table 4.23: Specific STI reported in past 12 months in quantitative phase

Infections	Lao (0)	Burmese (67)	Cambodian (26)
Gonorrhea	0	20 30%	9 35%
Syphilis	0	7 10%)	7 27%
Chlamydia	0	23 34%	0
Trichinous	0	4 6%	0
PID	0	0	10 38 %
Genital warts	0	0	0
Other	0	13 19%	0
Total	0	67	26

Researchers also asked participants if they knew whether they had been infected with an STI before starting sex work. Ninety-three percent of Burmese respondents, 85% of Lao respondents and 53% of the Cambodian respondents said they had not had STIs before starting sex work. Forty percent of Cambodian sex workers reported that they did not know if they had or hadn't been infected before beginning sex work, while only 15% of Lao respondents reported that they were not sure. Since HIV/AIDS are sensitive issues, researchers did not directly ask women for their HIV status. However, they were asked if they had been tested and whether they knew their results. Overall, approximately half of the group of participants who had been tested knew their results. Among Lao participants, 26% reported that they have been tested for HIV, with 85% of that group also reporting that they knew their results. Eighty percent of Cambodian participants

reported to have been tested, but only 45% among those participants knew their results. While 41% of Burmese participants reported having been tested, a mere 23% of that group reported knowing their results. This paralleled concerns raised in meetings with local health activists at Mae Sot and related NGO staff regarding the poor handling of HIV counseling and information dissemination in hospitals and clinics. Additionally, this indicates that even when migrant women receive medical attention or an examination, they are not always properly informed about the implications of what is happening to their bodies. This is a significant gap in the ways health services are made accessible to migrant women.

Researchers asked those who had had recent STI checks where they had got their tests done. Overwhelmingly, most of the sex workers surveyed reported going to a government health service institution, such as a public hospital or government STI clinic (over 80% of both Lao and Burmese women use government facilities) and nearly two-thirds of Cambodian sex workers responded similarly. Cambodian workers also went to private clinics either over the border or inside Cambodia. Further exploration of access to health services is offered in future sections.

Occupational Links

As noted in the qualitative phase, participants worked in either brothels, karaoke bars or independently. Within brothels, women were looked after and given medical assistance more often than women working in other venues. They were more often supported in situations where clients refused to wear condoms or acted abusively. By contrast, those working independently were found to be the most at risk – they had very little access to shared information on reproductive health issues, often worked in isolation (thereby vulnerable to abuse from clients) and were not connected to a peer group that could offer other valuable forms of support. Women working in karaoke bars were the least willing to call themselves sex workers for a variety of personal and political reasons. Those working in bars not identified as commercial sex establishments or those who worked independently were often neglected by social service projects on safe sex training and health outreach campaigns. These factors directly correlated to the reported rates of STI examinations among national groups.

Table 4.24: Frequency of STI examination in quantitative phase

Nationality	Once a week	Once a month	Once every 3 months	Once a year	Never
Lao (52)	0 0%	6 11%	2 1%	5 9%	39 75%
Burmese (178)	37 20%	88 49%	1 0%	7 3%	45 25%
Cambodian (193)	2 1%	62 32%	34 17%	30 15%	65 33%
Total (423)	39 9%	156 36%	37 8%	42 9%	149 35%

* 2 Burmese responses are missing.

Researchers asked women who knew that they were being tested for STIs how often they had been examined for STIs in the last six months. Rates for Lao women were the lowest, as 75% Lao women reported that they had not been examined. Twenty-five percent Burmese women and 33% Cambodian women said they had not been examined. Rates for being examined at least once a month were the highest in the Burmese group, where 49% reported they were tested once every month and an additional 19% reported being tested once a week. This was in contrast to the mere 11% Lao and 32% Cambodian women reporting being tested once a month. This is undoubtedly due to the presence of health organizations and STI services in the research sites, as well as the type of sex establishment where the women worked. In Mae Sot, there are several health NGOs working with sex workers. Also many sex workers in Mae Sot work in brothels. Not surprisingly, regular examination rates were significantly higher among participants in this area.[39]

Table 4.25: Place of STI examination in quantitative phase

Nationality	Government clinic/hospital	Private clinic	Private clinic arranged /contacted by employer	Others
Lao (12)	10 83%	1	0	1
Burmese (138)	133 96%	4	0	1
Cambodian (142)	92 65%	15	17	18

[39] These examinations are conducted as part of the government HIV prevention program under the Ministry of Public Health. The program is available widely in local and provincial public or government hospitals. In Mae Sot, where the Burmese workers were interviewed, the Mae Sot Hospital is known to be running a successful HIV prevention program, providing STI examination to all populations in the area regardless of their status.

Condom Use

Occupational: All the women interviewed had some awareness about safe sex practices and felt that they were entitled to be protected from sexually transmitted infections. They tried to have safer sex and protect themselves as much as possible, though were often limited by lack of support, language skills or negotiating power. In the qualitative phase, 40 out of 60 participants reported that they used condoms regularly with clients, though sometimes clients removed or refused to use them or paid less for sexual services with a condom than without one. Refusing to work with these types of clients is an incredibly difficult situation for many sex workers. Many women reported needing all the wages they could possibly earn. Several Cambodian and Thai sex workers reported symptoms (e.g. irritation and stinging sensation) that might be an allergic reaction to latex or the result of using condoms without lubricant. This was reported as another obstacle to regular condom use. On the other hand, these symptoms may have arisen from an STI that was not being treated. Many women stopped using condoms for reasons of comfort and continued to work without any method of protection.

> *In the beginning Nid used condoms but always had pain during intercourse and developed an infection. She has stopped using condoms and currently applies the withdrawal technique.*
>
> *Cambodian worker, 22 years old, working in a Karaoke bar*

Over half of the sex workers in the quantitative phase said they used condoms every time they had vaginal intercourse. Lao women had the highest rates for consistent condom use – 92% reported that they use one, either always or most of the time. This could be related to their higher Thai language ability, which allows them to negotiate with clients. Eighty percent of Cambodian sex workers reported they use condoms always or most of the time. Ninety-three percent Burmese workers reported that they always use condoms. In both the Burmese and Lao groups, women generally said they did not provide oral or anal sex services for their clients, though some Cambodian women said they did. Among the Cambodian participants, 82% of those who provided oral sex services and 45% of those who provided anal sex reported using a condom always or most of the time.

Table 4.26: Condom use for vaginal sex in quantitative phase

Nationality	Always	Most	Sometimes	Never
Lao (52)	47 90%	1 2%	0	4 8 %
Burma (180)	114 63%	54 30%	10 6%	2 1%
Cambodia (193)	126 65%	29 15%	34 18%	4 2%
Total (425)	287 68%	84 20%	44 10%	10 2%

Table 4.27: Condom use for anal sex in quantitative phase

Nationality	Always	Most	Sometimes	Never
Lao	1	0	0	0
Burma	1	0	1	1
Cambodian (31)	11 (35%)	3(10%)	5(16%)	12 (39%)
Total	13	3	6	13

Table 4.28: Condom use for oral sex in quantitative phase

Nationality	Always	Most	Sometimes	Never
Lao (5)	0	1	4	0
Burma (2)	0	0	0	2
Cambodia (72)	59 (82%)	2	11	0
Total	59	3	15	2

While the majority of women reported condom use, there were occasions when they did not insist on clients using a condom. If they were regular clients, were attractive or were polite, women would not insist. There were also women who were tricked by their clients into not using condoms.

> *With some clients whom I like, who are good looking and polite to me, I do not insist that they wear a condom.*
>
> *Cambodian worker, 22 years old*

> *With my regular client, I'm not always insistent. Sometimes we run out of condoms when clients take us outside the brothel for overnight services. Some clients lie that they are using one but just when they are about to penetrate, they reveal that they are not. Sometimes I have to agree to have intercourse without it. If I refuse, I will not get any money for the work done.*
>
> *Burmese sex worker, 21 years old*

Women received their condoms primarily from two sources. Among Burmese participants, 85% got their condoms free through hospitals or clinics. Other Burmese participants reported buying them at a store (7%), getting them from their employer (4%) or from a local NGO (3%). Cambodian and Lao sex workers, in contrast, primarily received free condoms from their

employers at 70% and 78% respectively, though 8% of Cambodian and 4% of Lao participants reported buying them from a store or their employer as well.

Table 4.29: Accessing condoms

Nationality	Buy from store	Buy from employer	Get free from employer	Get free from Govt. STI clinic	Get free from local NGOs	Other, friends, or client
Lao (52)	2 4%	2 4%	41 78%	3 6%	1 2%	3 6%
Burmese (180)	12 7%	1 0.5%	7 4%	153 85%	6 3%	1 0.5%
Cambodian (193)	15 8%	22 11%	135 70%	15 8%	6 3%	0
Total (425)	29	25	183	171	13	4

Personal Lives: In both phases of the study, women reported that condom use in their relationships with non-paying sexual partners was not as frequent as with clients. Many women reported that they felt it would raise questions of trust in their relationship if they asked their partners to use condoms, while others did not need or want to use condoms with their primary partners for other reasons. Many participants' non-paying sexual partners were reported to be former clients**.**

> *Nok doesn't use condoms with her boyfriend for fear that he would suspect her of being a sex worker if she asked him to use a condom. He does not know she does sex work to earn an income.*
>
> *Lao sex worker, 22 years old*

> *Som accepted to have sex without condoms with her boyfriend on his request, even though she was afraid of getting diseases from him. She told him to wear condoms with sex workers and always put them in his pockets. But he never used the condoms that she gave him. Som knew that her boyfriend had never used condoms with any of the women he had had sex with.*
>
> *Cambodian sex worker, 24 years old*

Eighty percent of the sex workers surveyed reported having at least one non-paying sexual partner, such as a boyfriend or husband. Seventy-nine percent Lao workers, 26% Burmese workers and 81% Cambodian workers reported having vaginal sex regularly with their partners

and using condoms always or most of the time. Cambodian participants were the only ones who had a significant number of respondents reporting that they engaged in oral or anal sex with their non-paying partners. Sixty-three out of 84 who reported having oral sex with their partners also reported using condoms either always or most of the time. Cambodian sex workers who reported that they have anal sex with their partners were divided, with 12 out of 27 reporting they never used condoms.

Table 4.30: Sexual relations with non-paying partner/s in past 6 months

Nationality	Yes	No sexual relation
Lao (35)	29	6
Burmese (179)	99	80
Cambodian (130)	125	5
Total (342)	253	91

Table 4.31: Condom use for vaginal sex with non-paying partner

Nationality	Always	Most	Sometimes	Never
Lao (29)	22 (76%)	1 (3%)	2 (7%)	4 (14%)
Burmese (99)	22 (22%)	4 (4%)	4 (4%)	69 (70%)
Cambodian (125)	67 (54%)	14 (11%)	34 (27%)	10 (8%)

Table 4.32: Condom use for anal sex with non-paying partner

Nationality	Always	Most	Sometimes	Never
Lao (3)	2	0	0	1
Burmese (1)	0	0	0	1
Cambodian (27)	9	1	5	12

Table 4.33: Condom use for oral sex with non-paying partner

Nationality	Always	Most	Sometimes	Never
Lao (4)	0	1	2	1
Burmese (5)	0	0	1	4
Cambodian (84)	62	1	16	5

Breakage and Correct Use of Condoms

In the qualitative phase, almost half of regular condom users reported breaks in condoms because of poor quality or misuse. Forms of misuse included wearing multiple condoms at a time and not using a water-based lubricant. Additionally, clients who have objects or penis-enhancement gels inserted into their penises often no longer fit standard-sized condoms. This causes the condoms to break leading to vaginal injuries in the women. Researchers followed up on this line of inquiry in the quantitative phase, with questions about condom breakage rates and ways that women

typically used condoms with their clients. These questions were posed to the sex workers within the framework of their occupational activities rather than what they did in their personal lives. When asked how many breaks or leaks women have experienced in their condom use at work in the past six months, less than half the group reported not having had a single break in the last six months. The highest breakage rates were reported by Burmese sex workers, with 60% reporting between one to five condom breaks or leaks; 11% had more than five; 52% said that they were sure they had not experienced a break or leak.

When researchers asked more details about condom use, in both the qualitative and quantitative phases, women reported high rates of clients wearing more than one condom at a time. In the quantitative phase, 32% of all sex workers surveyed said they used two or more condoms at a time. Cambodian women had the highest rate at 39%. Participants were also questioned about whether they thought there was any link between using multiple condoms and having condom break or leak. A majority (57%) of those who answered the question said they did not see a link. Additionally, only 6% of participants said that they used a lubricant, though 71% of those who reported using a lubricant did not know if their lubricant was oil or water-based. Nineteen percent of that same group reported that they were using an oil-based lubricant, which can break down the condom's strength.

Table 4.34: Frequency of condom rupture in past 6 months

Nationality	Never	1-5 times	More than 5 times
Lao (51)	41 80%	10 19%	1 1%
Burmese (179)	52 29%	108 60%	20 11%
Cambodian (192)	100 52%	87 45&	6 3%
Total (422)	193 45%	195 46%	27 6%

3 responses missing, one from each national group

Pregnancy

> *A business like this doesn't let pregnant women work because there is a belief that it will turn customers away. Some people really believe this. The boss told me to go home and to return only after giving birth.*
>
> *Cambodian worker, 20 years old*

Participants generally noted pregnancy as undesirable at this point in their lives. In the qualitative phase, women discussed the economic burden of having children and the fear of losing their job if they became pregnant. This question was complemented in the quantitative survey by a question about the number of live births and miscarriages in their lifetime. In the qualitative phase, 15 of 17 women who experienced pregnancy reported having had one to three live births. In the quantitative phase, 37 of 110 women had one live birth and 21 reported two or three. Rates of miscarriage were low.

Table 4.35: Reporting pregnancy in quantitative phase

Nationality	Yes	Never
Lao (52)	17 33%	35 67%
Burmese (180)	110 61%	70 38%
Cambodia (190)	76 39%	117 61%
Total	203 47%	221 53%

Table 4.36: Live births in quantitative phase

Nationality	1 time	2 times	3 times or more
Lao (17)	5	5	5
Burmese (110)	37	12	9
Cambodia (76)	37	12	9
Total	79	29	23

Table 4.37: Miscarriages in quantitative phase

Nationality	1 time	2 times
Lao (17)	2	0
Burmese (110)	13	1
Cambodia (76)	1	2
Total	16	3

Contraceptive Methods

> *Ekai was taking oral contraceptives and she also tried Depo-Provera but had side effects with both methods. Now she's using condoms and takes a traditional medicine - herbs with whisky, two times daily.*
>
> *Burmese sex worker, 30 years old*

In order to prevent their work from being interrupted by pregnancy, women used many contraceptive methods. In the qualitative phase, participants told researchers clearly that women using different forms of contraceptives (implants, injection method and oral contraceptives) had no access to consultation and follow-up care. Although many participants reported not wanting to get pregnant for fear of losing their job, very few of them reported continual use of contraceptive methods. Many qualitative participants reported going off contraceptive methods after a short time (less than three months) because of related side effects. Side effects identified were weight gain/bloatedness, erratic menstrual cycles and nausea. Possibly, if the women had been properly counseled about the correct use of the contraceptive or told that side effects from contraceptives become minimal over time, more women would have decided to stay with the method longer. Women in the qualitative group said that they use the traditional method to prevent pregnancy and to overcome side effects of other forms of contraceptives.

In the quantitative phase, the majority of participants reported that using condoms was their primary technique of preventing pregnancy (81% Lao, 70% Burmese and 48% Cambodian participants). Twenty-three percent Burmese and Cambodian participants reported using oral contraceptives, while small percentages (under 5% and 7%) reported using injection methods.

Abortion

> *Nid has thought a lot and realized she's not in a position to raise a child. Also, if she continues with her pregnancy, she has to leave her job, and she won't feel good if she goes home with a baby. There's only her mother and grandmother in Cambodia right now as her father and sister are in Samut Prakan province. She is currently asking around for a place that does safe and inexpensive abortions. She has heard the cost is about 2,000 baht per month of pregnancy. Some friends have also used abortion-inducing medication but have had very scary side effects, like heavy bleeding.*
>
> *Cambodian worker, 20 years old*

Abortion is illegal in Thailand, except in cases of risk to the woman's life or in some situations of sexual abuse.[40] Because of this, women who want to terminate unwanted pregnancies (and who cannot afford the high costs of a private clinic) are generally left to have unsafe abortions provided by traditional birth attendants (TBAs, both trained and untrained) or other members of their community. Crude and dangerous equipment and methods are often used. Methods that were reported to researchers included the insertion of sharp pieces of wood, candles and medicinal or herbal compresses; using hot stones or rough massage techniques on the lower abdomen; and taking both traditional and allopathic medicines in toxic amounts to induce a miscarriage. Women sometimes know how risky this can be, but often feel they have no other choice, particularly those who have been threatened by their employers with loss of job if they get pregnant. Some interview participants reported that in their area it is seen as bad luck to have a pregnant woman in a brothel, and the presence of one can drive away customers. Health care providers frequently do not find out about a woman's need for abortion until she comes in needing treatment for abortion-related complications. Complications reported by participants were: severe bleeding, vaginal and pelvic injuries and infections, burn marks and bruises in the abdominal region, excruciating pain and fatal blood infections.

> "*I am willing to have her [a pregnant employee] back at work. Actually, she could have been pregnant before she came to work here but she wouldn't tell me.It's up to her what her future will be. I don't really want to know about it. I don't support abortion because it's a sin. If she is going to do it, she has to do it herself. I won't help her with the costs."*
>
> *A 42-year-old Karaoke bar owner*

Among the qualitative sex worker participants, almost a third of the women reported having abortions. In the quantitative phase, abortion rates among Burmese participants were found to be the highest, with 50% participants reporting at least one abortion, and 11% of those reporting more than one. Among Cambodian participants, 54% reported having had an abortion, and 27% of those women said they had had more than one. Similar to other sensitive issues, these numbers are assumed to be lower than actual rates due to the stigma related to abortion. In a focus group with six TBAs active in the Mae Sot area, rates of abortion were reportedly much higher. The TBAs in this group spoke of experiences of administering abortions and assisting women who had complications.

[40] Lerdmaleewong, Malee and Caroline Francis. "Abortion in Thailand: a Feminist Perspective." *Journal of Buddhist Ethics* 5, February 1998, *22-48*.

Table 4.38: Abortions in quantitative phase

Nationality	1 time	2 times	3 times or more	Total
Lao (17)	0	0	1	1
Burmese (110)	45 40%	8 9%	2 2%	55 50%
Cambodia (76)	20 26%	11 14%	10 13%	41 54%

4.3.3 Psychological Well-Being

> *Kaw gets headaches when she thinks too much about her family; she also feels betrayed by her husband who was having an affair with a friend of hers. She has tried to kill herself twice. The first time she tried drowning herself but changed her mind when she pictured her child as an orphan. The second time, Kaw took about 30 sleeping pills but then vomited them all and there were no other effects.*
>
> *22-year-old Cambodian worker, currently working in a karaoke bar*

Since the definition of reproductive health that this study uses takes into account psychological well-being, researchers asked participants about the state of their emotional and mental health. Given that the Research Team was not made up of experts in the field of psychology, the Research Team still hopes that the findings can be used as preliminary data and catalyst for future studies on these important subjects.

In the qualitative research, researchers found that undocumented migrant status and being involved in an unregulated job sector all play a part in increasing sex workers' exposure to abusive or unsafe situations and reduce her options for seeking protection. Despite the vulnerabilities of their situation, many participants came across as resilient survivors, continuing to live a life amidst threats and risks of abuse, arrest and deportation. These factors necessitated inquiring into how participants cope with such situations and retain their emotional and mental well-being. Many women reported to have bouts of loneliness/isolation (16 out of 60 respondents), stress (16 respondents) and sadness/depression (12 respondents). Some responded to these feelings with habits of smoking (13 out of 60 women) and drinking (12 women), which were often first tried while working in bars or with clients. These activities have cumulative negative effects on their physical and mental health. Other women reported healthier coping activities like crying (7 women) which may be a tension reliever. Alarmingly, 17 participants said that they had tried to kill themselves at least once.

Table 4.39: Current mental health symptoms in quantitative phase

Mental health	Burmese (139) 77% of total	Laos (39) 75% of total	Cambodian (180) 93% of total
Boredom	42	4	33
Insecurity	15	1	27
Homesickness	1	0	1
Loneliness	4	7	19
Mood swing	14	7	8
Sadness	8	3	28
Sleeplessness	11	2	37
Stress	20	6	13
Upset	14	1	6
Worry/fear	10	8	8

When asked if they ever get depressed, only participants in the Lao group had a majority of negative responses. Over two-thirds said that they didn't get depressed in their work. In contrast, 64% Burmese and 92% Cambodian women reported that they did get depressed. In the quantitative group, women responded to these problems by crying (40%), drinking (13%) and doing nothing/trying to forget about it (28%). Interestingly, when the women were later asked about their alcohol and tobacco use (not in relationship to emotional well-being, but as an aspect of their lifestyle) positive responses were higher. These behaviors were directly related to their occupational tasks. In bars, women encourage customers to buy drinks. In these situations women drink more because they receive a share of the cost reported to be a substantial part of their regular wages. Over 20% of sex workers surveyed said they smoked, with the highest proportion of smokers (28%) in the Cambodian group. Over a third of the women said that they consume alcohol – 38% Lao and 55% Cambodian participants. Only 10% Burmese women reported consuming alcohol. This difference in numbers is not surprising as the majority of Lao and Cambodian sex workers work in bars, whereas the majority of Burmese sex workers work in brothels. However, it was only in the Burmese group that there was a significant evidence of other drug habits, with 10% women reporting that they had injected a drug before.

Reports of attempting suicide were much lower among quantitative participants, with only 1% of sex workers mentioning that that was how they had responded to emotional problems at least once before. Though again, this difference in rates may be due to the reduced feeling of trust and intimacy in the survey process compared to the relationships between researchers and participants during the qualitative survey. Surveyed sex workers also reported responding to emotional problems by talking with friends (mentioned by all three groups) and employers (mentioned mostly by Cambodian workers).

Table 4.40: Coping mechanism for depression in quantitative phase

How do you respond to or cope with depression?	Burmese (180)	Lao (52)	Cambodian (193)
Attempt suicide	3	0	4
Cry (40 %)	24	3	88
Cut myself	2	0	1
Drinking (13%)	2	0	38
Listen to music/sing	3	0	3
Talk to employer	1	3	17
Talk to friends	9	10	5
Do nothing/Try to forget about it (28%)	65	2	21
Other*	4	1	0
Total responses (311)	115 (64%)	19 (36%)	177 (92%)

*Others included minimal responses for the following: use sleeping pills, fight back, try to enjoy with a client and travel.

4.3.4 Access to Health Care Services

Accessing health services is a significant, and often daunting, predicament for many migrant workers. Fear of arrest and poor Thai language skills hinder many migrants from feeling safe in approaching health care facilities. Traveling to health care providers can be a risky journey, even when the distance is not particularly long, as migrants fear being spotted by authorities, arrested and/or deported. Checkpoints along roads in border areas, where migrants often live, increase the risk of this happening. Once they make it to the facilities, there is no guarantee there will be a translator available, and even when there is, the person may not be trained or be sensitive to the constraints of migrant women. There is also the economic hardship of visiting a physician, including transportation and prescription fees. Although low-cost health care is available to registered migrant workers in Thailand, most sex workers are not registered, do not have possession of their documents or are unclear about what registering entitles them to.[41] Any of these factors can combine to make seeking medical attention a highly undesirable experience, one many migrants avoid altogether.[42]

[41] For more information on how registration plays a part in migrant women's access to health services, see chapter 5 – Reproductive Health Care.

[42] As noted in *Tangled Nets* (p 24): "Migrant communities… avoid attention by hiding in undesirable locations where they endure unsanitary conditions. Many migrants are forced to live with up to ten or more people cramped in small, poorly ventilated rooms, or in ramshackle shanties that provide little protection from the elements.… Poor living conditions such as these have contributed to migrant communities suffering a disproportionately higher instance of disease than their Thai neighbors. Migrants also lack adequate preventative and general health care. Language barriers, fear of police, negative attitudes of health providers, inadequate information, and lack of transportation pose barriers to accessing general and reproductive health services for both documented and undocumented workers. As a result, minor ailments

Other obstacles hindering access to health services are related to occupational demands. As participants reported having to catch up on sleep or work during normal business hours, they can be hard-pressed to find enough time to take a trip to a doctor's clinic, or the government STI service that operates only once or twice a week. So if women had clients on those days, they would miss the regular STI check-up.

In qualitative interviews, researchers heard several stories of sex workers being treated rudely by health providers and translators at health care facilities. In the discussion on STI examination, women often spoke about verbal insults and insensitive behavior from doctors and nurses. Examples of this ranged from doctors and nurses publicly disclosing results of STI examination to ridiculing the women seeking their assistance. Women also reported non-availability of translators at health care facilities, which prevented them from explaining their symptoms to the doctor, and also understanding and complying with medical treatments.

> *At an STI clinic, while receiving an injection, Dah winced with pain. The nurse responded sharply, "Just a little injection hurts you, does it? Doesn't a man's dick hurt you more?"*
>
> *Burmese worker, 19 years old*

> *I wish I could get a clear explanation from a doctor or a nurse about what's happening to my body, what are the symptoms of my problem and if I should continue to work this time. But whenever a woman asks questions about her health problems, the doctor simply replies, 'Wear condom, wear condom!' If the doctor cannot say more because of the language, he should get a translator!*
>
> *Burmese worker, 17 years old*

Among the qualitative participants, there was a small number who reported positive treatment or care during hospital procedures, such as assistance with emergency care. Emergency care became a necessity for many participants who often tried to ignore moderate health problems until they reached critical levels. This avoidance of health care treatment may be attributed to personal safety issues as mentioned above or cultural taboos against drawing attention to one's body, particularly in the case of reproductive health problems. In the quantitative survey, less than a third of those who reported having a health problem in the past six months actually sought medical treatment. Almost two-thirds of the participants self-medicated by purchasing medicines

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are often left untreated until they require emergency care..." *Tangled Nets: The vulnerability of migrant fishermen and related populations in Thailand*, Raks Thai Foundation, *2003*.

from drugstores and a small portion of women just ignored the problem. The most commonly used medicines within these groups were paracetamol and various antibiotics, available without prescription in Thailand.

> *Lena went to a private clinic for an STI treatment and while she was treated very well, the fee, at over 6,000 baht [USD 150], was exorbitant. Also, the staff there did not offer her advice on avoiding STIs in the future. At the time of the interview, she did not know about contraceptives or safe sex and was not using condoms with her clients or her husband.*
>
> *Cambodian worker, 23 years old*

> *Saw, a Thai karaoke bar worker in Rayong, has had vaginal discharge and itching for almost two years. She has not sought treatment due to embarrassment. She bought herbal medicines from a mobile seller who came to the bar, but the problem persists.*
>
> *Thai worker, 27 years old*

Reports of accessing health care were much more positive among Thai sex workers, with over a third of interviewed participants mentioning that they had received good care through the 30-baht health insurance scheme implemented by the Thai government in the last few years. Clearly, there is less risk for these women in terms of transporting themselves to health care institutions and being able to communicate to the health care providers once they are there.

In Mae Sot, there is a tolerance policy for health care and HIV prevention initiatives by the government, which allows public health authorities to actively reach out to sex workers without any legal entanglements. The outreach includes condom and STI education. They work to promote a ‘clean house’ motto for commercial sex work establishments, meaning that all the women who work in the place are checked and have been found to be free of STIs. They have also done successful campaigns aimed at brothel owners, highlighting the economic benefits of healthy workers: more productivity, less turnover and happier clients means more money for the owners. The ‘clean house’ motto has turned into somewhat of a marketing mechanism for employers to showcase to clients, and has resulted in some employers forcing sex workers to get STI exams more than they want to. However, another benefit of attending the weekly STI checks are free condoms, which cuts down on costs for both workers and employers and improves condom use rates. Examinations are usually free after a small fee is paid to register workers, while medications are offered at a considerably reduced price. The Rayong provincial pubic health departments (Bureau of Aids, TB and STIs) manage STI clinics and some of them have special days aimed at sex workers, usually with euphemistic names like ‘Housewife Day’ or

'Waitress Day' to avoid legal problems in a country where sex work has not been legalized. These programs have been directly influenced by other local policies. In places where there are 'no brothel' campaigns being upheld by the community or local authorities, outreach programs for sex workers cannot exist as freely.

4.3.5 Health Information Desired

While sex workers in Thailand have been the target population of educational and outreach campaigns, even participants who have been through trainings reported that there were still notable gaps in the information they received. All quantitative participants were asked about the kind of health information they would like to receive the most in the future. Among Burmese sex workers, the three most mentioned health information topics that women wanted to know more about were: cancer, HIV and menstruation. Among Lao sex workers, the most cited were HIV and STIs, with an equal number of women responding that they wanted 'all information' possible. Cambodian participants cited HIV, safer sex and cancer as their top three choices of desired health information.

4.4 Future Plans

> *Jinda plans to return home at the end of the month but she still doesn't know what work she can do in the village. She just wants to return home because everyone in her family has now gone home. "There's no one here to care for me, and this kind of work doesn't pay enough. I'll go home first and think later what to do."*
>
> *Cambodian worker, 19 years old*

> *Sunda, after facing abuse on the job, is tired of sex work. She doesn't want to do it anymore. She has decided to work for three more months. Then she will quit and return home to open a shop in her village.*
>
> *Burmese worker, 28 years old*

Imagining and planning for the future is fraught with uncertainties for migrants, particularly those working without work permits or documentation in their destination country. The uncertainty of their current situation – not knowing if they will be arrested and/or deported, continually having to negotiate wages, facing violence and abuse in one's working environment – can often make one feel that the future is not controllable. Yet, having a goal can result in more focused choices. At the time of closing the interview and the survey process, it was important to support the participants who did have a future plan by listening to them, and encouraging the ones who didn't by asking them to voice their feelings about the future. In general, the Research Team felt that in discussing their future plans, participants demonstrated their agency, self-reliance and determination.

Over half the quantitative participants had some plan for the future. Most of the women surveyed did not plan to work in their current occupation or establishment for more than six months, with another 37% wanting to work for 6-12 months. The Burmese group reported opening a bar or shop at home in Burma, followed by living at home with husband and/or children. Among Lao sex workers, almost half of the group cited working on a farm or in rice fields as their future plan, followed by opening a bar or shop at home. Cambodian participants had the highest percentage of respondents reporting that they didn't know or didn't have a future plan yet, though opening a bar or shop at home was a popular pick among respondents who did have a future plan.

Table 4.41: Future plans in quantitative phase

What is your future plan?	Burmese 180	Laos 52	Cambodia 193	Total 425	%
Don't know/no plan yet	28	5	154	187	44 %
Bar or shop at home	91	13	16	120	28%
Live at home with family/husband/children	27	1	4	32	7%
Farm/ work in rice fields	19	23	8	50	11%
Get married/ be a housewife	3	3	1	7	1%
Work in Bangkok	6	3	0	9	2%
Build a new house	3	3	0	6	1%
Shop/drugstore/factory	0	0	5	5	1%
Beer promotion Phnom Penh	0	0	2	2	.4%
Others*	3	1	3	7	1%

**One Burmese woman wanted to become a nun and two women wanted to continue in sex work; one Lao woman wanted to do domestic work.*
** A Cambodian woman wished to buy a motorbike, and another woman wished to work in a casino.*

4.5 Conclusion

Sex workers were more mobile than women in factory or domestic work. Those who were going into sex work usually knew the details about their future occupation if they had done sex work before or had close connections with other migrant sex workers. In several cases, sex workers had migrated with the intention of doing other types of work, but either ended up not liking that type of work (it was tiring, strenuous or did not pay enough) or there were no jobs available at that time. However, a large number of women reported being lured or forced into this sector at some point. The women in both phases of the research tended to be young (usually under 30 years old) and not married (single or widowed/divorced). Over half the quantitative participants began sex work between the ages of 15 and 20.

Sex workers have a relationship of dependency with their employers. The protection that employers provide them can also lead to exploitation and abuse or a mixture of both. Employer attitude had an effect on their feelings toward the work. A participant felt supported when employers negotiated with troublesome clients. In more favorable situations, workers reported that they could decline from servicing clients who refused to wear condoms or acted in harmful ways. In contrast, other participants felt pressured to service a client regardless of his behavior. Another example of employer support was in terms of employers providing transportation for workers when needed, such as traveling to STI clinics for examination or to outside locations for work on a client's request. There is, of course, a thin line dividing employer-protection and employer-control. For instance, it was reported to be important that migrant women be able to live close to their workplaces to avoid trouble from the police or to avoid risking arrest when traveling through checkpoints. However, employers used this proximity as a means of control. They knew where their workers were at all times. In such situations, workers can become more dependent on the employer than they would if they had been living in a separate space. This results in loss of self-confidence and limited understanding of the local area and other resources available to them. This also allows employers to have more control over deductions from their wages for essentials such as rent, food and other necessities.

The study also found that the kind of workplace, ranging from brothels, karaoke bars to independent accommodation, had differing impacts on their reproductive health. Within brothels, women were looked after and given medical assistance (regular STI checks) more often than women working at other venues. Women in brothels were more often supported in situations where clients refused to wear condoms or acted abusively. By contrast, those working independently were found to be the most at risk as they had very little access to shared information on reproductive health issues, and often worked in isolation (allowing for increased abuse from clients) with no connection to a peer group that could offer valuable support. Women working in karaoke bars were the least willing to call themselves sex workers for a variety of personal/political reasons. Women who worked in bars that were not identified as commercial sex establishments or who worked independently, were often neglected by social service projects such as safer sex trainings and health outreach campaigns. These factors had a direct bearing on reported STI checks and violence against them in the form of abuse, sexual assault, rape and sexual harassment. Burmese workers reported the highest rate among the groups.

Rape is an unspoken abusive experience among women. Many women had experienced gang rape by the police or the military, as well as by other migrant workers. None of the women complained or tried to seek justice. Rape is a fate that women doing sex work have no control over. Nonetheless, women tried to empower themselves by creating self-help groups among themselves. With the help of mobile phones during emergencies, they kept each other informed about untrustworthy clients and unsafe hotels.

Sex workers in Thailand have been the target population of educational and outreach campaigns. Even then, participants who have been through trainings reported that there were still notable gaps in the information they had received. Women felt they do not have adequate health information on cancer, HIV and menstruation. Condoms are widely used among sex workers, though quality is an issue, as many condoms break during sexual intercourse. Sex workers tend not to use condoms when having relationships with non-paying sexual partners. Many women reported that they felt it would raise questions of trust in their relationship, if they asked their partners to use condoms.

A specific obstacle to sex workers' access to health services is related to occupational demands. As participants reported having to catch up on sleep or work during normal business hours, they could be hard-pressed to find enough time to take a trip to a clinic. Sex workers also reported of being treated in disrespectful ways by health providers and translators at health care facilities. In discussions on STI checks, women often commented on exposure to verbal insults and insensitive behavior from doctors and nurses. Examples of this ranged from doctors and nurses publicly disclosing results of STI exams to ridiculing the woman seeking their assistance.

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CHAPTER 5

Reproductive Health Care

As reproductive health care of women migrants constitutes a major focus area of this research study, we consolidate and deploy the findings of this study to provide an analysis of the options for reproductive health care and the realities of access to that care available to migrant women. This discussion will be contextualized in terms of the health care choices for migrants in Thailand, specifically with a description of the health benefits for registered migrant workers. The discussion in this chapter will also pull together the realities of how women across three sectors of work actually took care of their reproductive health. Since abortion figures as a key issue in reproductive health care, the chapter also delineates the legal and cultural implications of abortion and how these impact on the choices that migrant women make.

5.1 Health Care: Options and Realities

5.1.1 The Thai Context

In 1996[43] the Thai government started to phase in a policy of registration for migrant workers from Burma, Cambodia and Laos[44] in several occupational sectors including construction, domestic work, factory work and agricultural work.[45] For migrant workers, this has historically meant that they must register and acquire a work permit during the scheduled time period or they risk arrest and deportation. But the 2004 registration was dramatically different. Migrants were required to initially register as temporary residents (not workers). This included registering one's place of residence, photo and fingerprints. Following this was another phase of registration that included registering those who wished to work in Thailand. Migrants would then receive their own temporary ID card, totally independent of an employer. At the same time, employers were obligated to request the specific number of migrant workers their business required. In the second

[43] While the registration process began in 1996, it gained additional wide-scale attention in 2001, when it opened up to an unlimited number of migrants and no longer required an employer with the migrant. See "Date Set For 'illegal'." *The Nation*, 4 September 2001. See also: "Op to Million Aliens Targeted." *The Bangkok Post*, 9 July 2004.

[44] In the 2004 registration process, about 1.2 million Burmese, Lao and Cambodian workers registered in total. There were more than 800,000 Burmese registered (70% of the group) and more than 180,000 Lao workers. The gender make-up of the group was slightly in favor of men, with more than 660,000 males and 550,000 females having registered. See "Time Has Run Out: for registration of migrant workers." *The Nation*, 1 August 2004.

[45] See "Date Set For 'illegal'." *The Nation*, 4 September 2001.

phase of the registration process, both migrant workers and employers registered for work permits. All migrants who were applying underwent a medical check, paid a health insurance fee that then entitled them to reduced fee health insurance. Migrants with work permits were also entitled to protection under the Thai labor laws.[46]

Mae Sot Women's Center

In terms of health care consequences of this registration process, two issues are notable: migrant workers undergo a mandatory health check before they can be officially employed and they are able to access low-cost health care at public hospitals in Thailand. Health checks include a physical exam and tests for TB, leprosy, elephantiasis, and syphilis. If a migrant is found to have one (or more) of these diseases, they can be treated and still receive a work permit, unless they are in an advanced stage of the disease. They are also tested for drug addiction, alcoholism and mental health problems. Prior to 2004, migrants would be deported if they failed these tests. However in 2004, these three conditions could make a migrant ineligible for a work permit but did not constitute grounds for deportation. According to the policy, testing for pregnancy is also included in the health check-up, but no details are provided in the policy as to whether pregnancy is a condition that would make a migrant ineligible for a work permit.[47] Many participants in the study were under the impression that the pregnancy test was a critical and deciding factor in being allowed to stay and work in Thailand. Additionally, other participants reported being told by medical staff that they were also being tested for HIV during their registration exam.[48]

While the screening process may be a worthy public health goal (in terms of reducing the number of communicable diseases in close working and living conditions), this policy can also lead to negative consequences. For example, if migrant women are not eligible for a work permit as a result of pregnancy, they may feel it necessary to abort (in rushed, inexpensive and unsafe ways), not register for work permits or go back to their country of origin, regardless of how long they

[46] Action Network for Migrants. "Registration of Migrant Workers 2004." Thai Labor Campaign website: http://www.thailabour.org/wnews/040613-1.html

[47] Some hospitals say that they do not conduct pregnancy tests; others have said they test for pregnancy but don't deport or refuse work permits based on this.

[48] In a discussion with a public health officer, it came to light that a random test for HIV among migrant workers, especially sex workers, is under the monitoring of the HIV epidemics program for HIV prevention.

have already been working in Thailand and their dependence on wages. Additionally, if they are obligated to return to their country of origin, they may not have access to adequate health care. On the other hand, once workers have registered, had the medical exam and have paid the insurance fee, they are entitled to medical treatment under the Thai 30-baht health care scheme. This health insurance costs migrants an initial fee of 1,300 baht and then only 30 baht for most routine treatments at public hospitals. Migrants are generally offered the same plan as available to Thais, with the exception of being covered for the delivery of their first child and heart treatment. This is a far better health insurance program than many migrants have been entitled to before. But there are still some shortcomings. While this plan assures registered migrants that they will not be arrested during transportation or treatment process, being cut off in the middle of long-term treatments is a concern. Also, the success of this policy is highly dependent on migrants receiving adequate information about the services to which they are entitled and having the support of their employers to actually use them.[49]

Of course, for many migrants, the registration process is an elusive and mysterious prospect and the consequential benefits remain out of reach. But for those to whom it is accessible, the registration can prove to be quite expensive, as they might have spent their savings on the migration process itself or on a variety of personal needs (e.g. medical care, debts and/or familial support).[50] Fees to register and obtain a work permit are high: six months costs 2,900 baht and one year costs 3,800 baht. (This fee includes 600 baht for the medical check-up, 1,300 baht for the health insurance plan, 100 baht for the work permit card, and additionally 1,800 baht for a year's work registration fee, 900 baht for six months or 450 baht for three months.) Other costs include transportation (visits to the district or sub-district offices for registering, and to the nearest public hospital for the medical check-up), medicines needed to treat conditions diagnosed during the check-ups and time taken off work to complete all the necessary tasks.

Undoubtedly, the difficulty for migrants to afford these costs is related to the lack of implementation of labor laws obligating employers to pay migrant workers the minimum wage. Although this is also a part of the same registration policy, it is not upheld with the same kind of attention as rules and regulations regarding migrant residency in Thailand. Additionally, migrants

[49] In 2004, the Labor Ministry was heavily attacked for its poor public relations work, resulting in a lack of proper understanding of registration procedures on the part of both employers and employees. "Confusion Reigns on First Day of Worker Registration." *The Bangkok Post*, 2 July 2004.
[50] Estimate of monthly earnings of women interviewed: 2500-4000 baht (62-100 $) from sex work, 1500-2500 baht (37-62$) from factory work and 700-1500 baht (17-40$) from domestic work.

working in the sex industry or other un-legalized and unprotected sectors are not entitled to the benefits of registration. Rather than decreasing the number of risks faced by these workers, registration can actually make them more vulnerable. This is particularly the case during the period following registration,[51] as large-scale anti-undocumented migrant campaigns take place, resulting in the mistreatment, arrest and deportation of many migrants by the police and the immigration officials.[52]

5.1.2 Modern Health Care Institutions

For migrants who do not, or cannot, utilize the registration process to access health care services, there are some other options available such as public and private hospitals, private clinics and specialty clinics. Participants in this study discussed using each of these options with various degrees of success and satisfaction. In general, those who tried to access medical institutions risked arrest during the journey and while at the health center. This major and constant fear thus is a significant deterrent in accessing health care. Public hospitals were found to be less expensive than private ones. While several participants mentioned receiving positive treatment at private hospitals, treatment costs were difficult for them to afford. Specialty NGO clinics, such as the Mae Tao Clinic, were found to be the most convenient and adequate in terms of meeting the needs of migrants in this study. Participants discussed the sliding scale fees and the availability of translators or services provided in their language as major incentives for them to use clinics. In some situations, a public hospital was discussed as offering a specialty clinic for particular medical treatments, such as STI tests. During the periods these clinics were offered, rules and regulations of the hospital would be relaxed and the treatment of undocumented migrants would generally be allowed.

5.2 Reproductive Health Care Accessed by Migrant Working Women

Apart from general health care services, women in this study sought assistance options for their reproductive health care. These include medical examinations for sexually transmitted diseases, HIV and others symptoms related to reproductive health.

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[51] On the day after the registration deadline, "police will enforce stricter rules in arresting unregistered foreign workers and preventing them from continuing to work in the country. 'Illegal foreign workers will be jailed for three months and/or fined up to Bt 5,000. The employers will be jailed for no more than three years and/or fined up to Bt 60,000.' " Police spokesman Maj-General Pongsapat Pongcharoen as quoted in: "Time Has Run Out: for registration of migrant workers." *The Nation*, 1 August 2004.

[52] Tunyasiri, Yuwadee and Penchan Charoensuthiphan. "PM warns officials against leniency on alien workers." *The Bangkok Post*, 3 July 2004.

5.2.1 Examinations

A limited number of participants in all three sectors reported being tested and treated for STIs in various ways. Sex workers who worked in brothels, particularly those living and working in Mae Sot (the research site used for contacting most of the Burmese participants), were tested more regularly than participants in other categories. Seventy-five percent of Burmese sex workers reported having been tested for STIs in the last six months and 88% of those cases reported being tested at least once a month. Sixty-six percent of Cambodian sex workers reported having been tested in the last six months, with 62% of those respondents reporting that they were tested once a month or more. As the public hospital in Mae Sot offers weekly free STI tests for sex workers, almost all of those who reported having been tested also reported being tested at government health facilities. The majority of Cambodian sex workers reported similar results. However, a number of them stated that they had gone to a private clinic for testing. Notably, tests at private hospitals were more expensive than those offered at reduced fees or free of charge at public hospitals and related clinics. Factory and domestic workers were not asked these questions directly during the quantitative survey, but responses during interviews mirrored those from the survey, with Burmese participants from Mae Sot having undergone STI tests more than other participants.

All participants were asked whether they had been tested for HIV and if they knew their results. Differences between the responses to these two questions were clear indicators of the gaps in the dissemination of health information to migrant women by medical staff. Sex workers had the highest number of responses that they had been tested for HIV, yet they also had the highest number of not knowing their HIV test results.[53] Fifty-nine percent participants who had been tested did not know their results, whereas 27% domestic worker participants and 8% factory workers did not know their results. This may be due to outreach programs that have reached more factory workers than migrants in the other sectors. In any case, it is alarming that so many respondents in each group reported they had been tested for HIV but did not know their results. Many of them told the researchers that they were living their life in fear of being tested positive, but they feel easy and relaxed when they don't receive information, assuming that the results

[53] "Sex-workers in Thailand have been routinely tested for HIV, but when counseling is provided, it is [sic] only been provided in Thai language. It is common that women from Burma have been tested for HIV without understanding what they are being tested for or even what HIV is. A positive test hardly changes their circumstances in any way." *Migrating with Hope: Burmese women working in the sex industry*. Images Asia, Thailand. July 1997. *37.*

must be negative. It must be pointed out that since random checking is done on a large number of migrants, follow-up process and treatment in case of positive results are not prioritized.

In cases among the qualitative groups, where the participants had been through a number of medical tests but did not know the results, language problems were often to blame. At both public and private hospitals, workers who had little knowledge of Thai were at a clear disadvantage. They were unable to discuss medical issues with their doctors. This hindered participants from being able to ask questions about conditions, as well as being able to understand explanations of what was being tested and how conditions were being diagnosed. The Mae Tao clinic was mentioned as a commendable exception, offering information on both tests and results in languages such as Burmese and Karen. Such alternative medical services are not available for migrants of other nationalities.

5.2.2 Medical Treatment

Many factors influence a participant's choice of seeking medical attention for reproductive health problems and pregnancy/delivery care. The major factors that discouraged health care being sought were: fear of arrest during the transportation process or while seeking treatment, costs of the treatment and inability to communicate with medical staff due to an absence of translators or staff who could speak the same language as the migrant. Added to this list of deterrents were cultural taboos around speaking about reproductive health and sexual activity. Past negative experience at a medical center, even if only once, was often mentioned as reason enough for not returning to that medical center, or in some cases, any medical centers at all. Encouraging factors, of course, tended to be the opposite of these: an assurance that arrest was not a threat, being accompanied by employers or management staff to the medical site, and being aware of the benefits of having a work permit (and actually possessing one as well). Other encouraging factors were the presence of medical centers which offered care in migrants' languages and again, having a positive experience at a medical center, or in some cases, hearing about a positive experience of a friend or family member.

5.2.3 Alternatives to Allopathy Treatment

Participants who did not seek medical assistance for reproductive health issues at the hospitals and clinics described above tended to do one or more of these: ignore symptoms and seek medical care only when critical, self-medicate with allopathy medicines, self-medicate with traditional medicines or practices, and seek care from traditional healers or birth attendants.

Leaving Symptoms Until Critical

In all three sectors and in both the qualitative and quantitative groups, participants discussed ignoring health problems often. In the quantitative study, participants were asked how they treated health problems they had had in the last six months. Twenty-four percent of domestic workers and factory workers, and 6% sex workers reported not responding to any health complaint they had had in the last six months (including the one at the time of survey). Additionally, 24% factory workers, 23% sex workers and 19% domestic workers who reported that they had current health problems, also reported that they had not been sick in the last six months. This later data may indicate participants' sense that a person must be severely ill to warrant medication or medical treatment. Both sets of responses imply a cultural tendency or perhaps economic reasons to ignore health complaints. In interviews, this dilemma was also apparent in participants' discussions of what they did seek treatment for – namely, severe fevers, injuries or other critical situations. Participants reported seeking treatment only after experiencing moderate symptoms of common reproductive health problems, vaginal infections or other conditions for long durations or in escalating phases. Unfortunately, this often led to health problems becoming irreversible, increasingly harmful and very expensive to treat.

Self-Medication Methods

Self-medication was indicated as a favored response to many health problems. Forty-nine percent sex workers, 43% domestic workers and 51% factory workers who reported having a current health problem, also reported that they responded to their health complaints in the last six months by self-medicating. In discussions on self-medication, there was often a mention of the role of pharmacies and traditional medicines and practices.

Pharmacies and merchants selling commonly used drugs in their shops were reported to be a major access point for medicine and health-related information. Particularly valued were mobile drug stores which come to factories, brothels and migrant areas to sell medicines. In all three forms (pharmacies,[54] small shops[55] and mobile drug stores[56]), access to medicines was easier than at hospitals because of the lack of paperwork, reduced costs and extensive translation.

[54] Most of the time women got medicines from a shop assistant and not necessarily from a pharmacist.
[55] Small grocery shops situated in the area sell painkillers, antibiotics and some herbal medicines.
[56] Commonly visible in Cambodian and Burmese communities, these medicines are brought from home by migrants or relatives for sale in the community or workplace. In one of the communities in Rayong, a researcher found the mobile seller also selling pills for regulating menstruation, a medicine used when a woman suspects pregnancy or when she's had sex without contraceptive.

Additionally, as shops and mobile stores were common in areas where participants worked and lived, the risks involved in transit were also reduced. In some cases, staff spoke the migrant's language and would offer diagnosis and assistance to participants, though this advice was not always found to be medically sound. While researchers did not interview pharmacy staff, in other studies, they have been found to be both trained and untrained as medical advisors. Participants frequently used these channels to purchase contraceptives, including packages of oral and injectible contraceptives. However, their correct use was not always explained to participants and did not sufficiently make up for the lack of consultations with trained medical personnel.

Traditional medicines and practices were also heavily relied upon for self-treating, particularly for reproductive health problems. Although some traditional practices and medicines were testified by migrants as being beneficial, this was not always the case. It was also noted that participants' dependence on traditional self-treatment, or belief in traditional explanations regarding health indicators occasionally hindered their ability to understand the acuteness of their medical condition and the necessity for more comprehensive treatment. This was particularly observed in the case of reproductive health complaints.

Traditional Birth Attendants and Healers

In line with traditional beliefs, practices and self-treatment, participants discussed seeking assistance from traditional birth attendants (TBAs) and other traditional healers to help with pregnancies, deliveries, and reproductive and general health problems. Factors determining this decision were: shared language with the healer or TBA, low costs, familiarity with the methods being used or with the person, and easier access to the person because they tended to be part of the migrant community. Additionally, participants reported discussing health conditions with TBAs and traditional healers with notably less embarrassment or feelings of taboo, than with doctors or other medical professionals. In line with other researchers working with migrant populations, this study uses the term TBA "broadly to refer to anyone as having experience in birthing, whether such person has formal training or not".[57] This use does not disregard the significance of training programs for TBAs being offered by health-based NGOs such as the Mae

[57] Caouette, T. et al. (2000) *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*. Institute for Population and Social Research, Bangkok. *Footnote no. 42*.

Tao Clinic and Médecins Sans Frontières (MSF).[58] The term traditional healer also referred to both trained and untrained individuals.

TBAs[59] are particularly called upon for assistance during deliveries. Only a few participants discussed using them for prenatal care. Returning to the country of origin was an ideal for many participants, as they could use the TBAs known to them. Also family support during this time is very important. This support is not just emotional, but also allows them to take time off work and to care for their physical needs as well. In the case of several factory workers, particularly those from Cambodia, leaving the child in the country of origin was favored, as it was reported that the restrictions of living and working conditions in Thailand were not favorable to raising a child. In some cases, returning to the country of origin was done to seek contraceptives or other reproductive health care. This did not always mean a trip to the participant's hometown, but just crossing the border.

Other interviews revealed that some participants did not feel they could return 'home' for care because of an element of shame about their current situation. Reasons for shame included not being married, not having an ideal job, not having earned much money since migrating and having 'lost face' because of involvement in incidents seen as scandalous. Such events included being sexually abused, or a recent marriage/relationship break-up.

5.3 Abortion

One of the key issues that came to light in both the interviews and surveys was unsafe abortions. This section briefly discusses the legal and cultural implications of abortion in the Thai context, and also the legal issues surrounding abortion in the participant's country of origin. Following that will be a discussion of factors that influence women's decision to abort, persons who perform the abortions, abortion methods being used and the consequences of these methods. In Thailand, abortion is illegal[60]except in cases where the woman's physical health is in danger or where

[58] For information on the Mae Tao Clinic's TBA training program, see Maung, Cynthia and Susan J. Purdin. "Reproductive Health Services for Burmese Refugees on the Thai-Burmese Border." *Sexual Health Exchange*. Royal Tropical Institute, Zimbabwe. No. 2, 2000.

[59] In one of the focus group discussions with TBAs at a research site, it came to light that TBAs were providing healing, using both the traditional methods and allopathic drugs. The services included Depo injection, temporary sterilization for women, and abortion.

[60] In 2001, the offense of carrying out illegal abortions carried a "five-year sentence and 10,000 baht fine or both … having abortions, [is] a crime that carries a three-year jail term, a fine of no more than 6,000 baht, or both". Whittaker, Andrea. "Conceiving the Nation: Representations of Abortion in Thailand." *Asian Studies Review* 25, no. 4, 2001. 436.

pregnancy is the result of rape or incest. Since this law (Criminal Code – Section 305) came into being in 1956, there have been several periods of active campaigns attempting to make abortion legal. In "Conceiving the Nation: Representations of Abortion in Thailand" by Andrea Whittaker and "Abortion in Thailand: a Feminist Perspective" by Malee Lerdmaleewong and Caroline Francis, it is reported that these debates have historically left out the voices, motivations and experiences of women who have considered or had abortions. A crucial feature instead is the image of an ideal Thai woman, which Whittaker says incorporates a sense of modernity without compromising the role of a graceful mother upholding Thai-Buddhist values. This being the case, debates around changing abortion laws in Thailand have centered on the definition of Thai-Buddhist values and tradition. Notably, conservative voices have won out in favor of a particular understanding of Buddhist morals that advocates against abortion as "a product of corrupt western materialism and its ascendance over spirituality in the present age".[61] In these discussions, women who have had abortions are often conceptualized as immoral, unmarried, students or sex workers. In some cases, they are represented as innocent victims who need protection from the havoc of uncontrollable men. However, in the most recent large-scale study of abortions in Thailand, it came to light that most women who decide to abort are married women over the age of 20, who, for a variety of reasons, do not feel that they are ready to carry a pregnancy to term or to raise a child or have another child. The primary motivations cited for inducing abortion were socio-economic.[62] Additionally, in response to mainstream views that abortion is a type of Buddhist 'sin', alternative Thai-Buddhist viewpoints on abortion have arisen, but have not received much public attention.[63]

In the participants' countries of origin, abortion regulations differed from those in Thailand. In Burma and Laos, abortion is only allowed in cases where it must happen in order to save the woman's life.[64] In Cambodia, there is much less restriction and abortion is generally allowed

[61] Whittaker, Andrea. "Conceiving the Nation: Representations of Abortion in Thailand." *Asian Studies Review* 25, no. 4, 2001. 424-451.
[62] "Report Estimates Level of Abortions." *The Nation*, 30 October 2001.
[63] For example, "Phra Mano Mettananot of Wat Raja-ook proposed a new way to interpret human birth. He suggested that during the first trimester of pregnancy the embryo had yet to develop consciousness and could not be regarded as a full human being." As cited in "Report Estimates Level of Abortions." *The Nation*, 30 October 2001.
[64] Strict illegality of abortion and the lack of widespread use of contraceptives have created a dire situation in Burma. The Myanmar Health Department "ranks abortion in their top ten health problems for the country and the third main cause of illness. The estimated maternal mortality is 255/100,000 and at least half of the deaths of women due to pregnancy-related reasons were related to abortion." Belton, Suzanne and Cynthia Maung. "Fertility And Abortion: Burmese Women's Health on the Thai-Burma Border." *Forced Migration Review*, no. 19, January 2004. 36-37.

without a specific reason being necessary. However, abortions in Cambodia are only allowed in the first 14 weeks of gestation.[65] Regardless of the legal standing, unsafe abortions and complications resulting from them have been reported in each of these countries.

5.3.1 Factors and Determinants

Factors in participants' consideration of abortion were wide ranging. In all three sectors, participants felt that their current occupations discouraged pregnancies. In some cases, this was made more pronounced by employers stating outright that a worker would lose her job if she became pregnant. She also risked not obtaining a work permit as a result. In cases where employment risks were not spelled out, women discussed other hardships in becoming pregnant. These hardships were not only the economic costs of raising a child, but included concerns about the costs involved in taking time off work for pre- and postnatal care, the costs of needing to find other living accommodations due to space limitations at their current place of residence and perceptions that their work schedules left no time for child care. These concerns were sometimes amplified by the state of the relationship the participant had with her partner. In cases where the participant's partner was not seen as supportive or present, the participant was more likely to feel pressured by economic and time constraints. As abortion was typically a response to an unwanted pregnancy, other factors that influenced participants' likelihood of having an abortion was whether she had access to means of preventing pregnancies. Deterrents for participants' use of contraceptive practices included limited access to or knowledge of contraceptive methods, misuse of contraceptive methods resulting in unwanted pregnancies and the influence of partners in the choice to use contraceptives (particularly condoms). Side effects were another notable deterring factor in participants' continued use of oral and injectible and implant contraceptives, although, this was seen by researchers as largely a consequence of substandard medical consultation. All of these concerns and factors were discussed by women who didn't have children at the time of interview and also by those who had had children already, but felt that another child would be a considerable strain on their resources.

Interviews with sex workers showed that women tended to use condoms with clients but not use them with romantic or otherwise non-paying partners. This made the distinction between the two sets of sexual partners evident. The practice of not using condoms denoted a sense of increased

[65] "The World's Abortion Laws." Center for Reproductive Rights, June 2004. http://www.crlp.org/pub_fac_abortion_laws.html

intimacy and trust in the relationship, established by the participants and also encouraged by the romantic partners.[66]

5.3.2 Means and Methods

Abortions were reported to happen through private clinics, assistance from TBAs and by self-induced methods. While private clinics may be the safest and the most hygienic option for women to have an abortion, they are also the most expensive and are not a guarantee for quality medical treatment. It has also been reported that because abortion is illegal in Thailand, private clinics do so below board which implies that the process is rushed and the fee charged is very high. Additionally, the same deterrents to seeking medical attention mentioned above (in terms of language and risks of arrest), apply in this situation as well. In only a couple of cases did participants mention this as an option for themselves or friends.

As a result of the inaccessibility of safe abortion options, participants with unwanted pregnancies seek abortions from TBAs and through self-induced methods. Methods used by TBAs included insertions, massage and abortifacients. Insertion methods are often used by TBAs who insert wooden sticks with sharpened ends into the participant's vagina until the uterus is punctured. Other tools used for this same method are candles, twigs and other parts of a plant. A different kind of insertion method requires inserting cotton wool soaked in abortifacients or inserting traditional herbal abortifacients. In both of these cases, the medicine compact stays inside the woman's vagina until she starts bleeding. This process sometimes goes on for a number of days. In other cases, women mentioned having a TBA massage their lower abdomen in ways that dislodges the embryo or the fetus from the uterine wall leading to a miscarriage. This method can also involve the use of heavy stones which are heated up and then placed on the abdomen. Participants also discussed taking oral medicines, both traditional and allopathic, to induce an abortion. The latter is sometimes self-prescribed or by TBAs.

5.3.3 Complications

The World Health Organization (WHO) has estimated that almost 50% women globally develop complications after undergoing unsafe abortions, and 80,000 women die every year due to those complications.[67] Of course, the real numbers may be notably higher than these figures, as

[66] This tendency was also discussed in Caouette et al. among other studies.
[67] WHO – World Health Organization (1998a, accessed 2000, June 16). World Health Day/Safe Motherhood, 7 April 1998: Address Unsafe Abortion (WHD 98.10) http://www.who.int/archives/whday/en/pages1998/whd98_10.html

abortions are done covertly and rates tend to go unreported. Since abortions are not uncommon, it is not surprising that many women in this study discussed complications that they or their acquaintances had experienced. The complications that these participants reported included severe bleeding, vaginal and pelvic injuries/infections, burn marks and bruises in the abdominal region, excruciating pain and fatal blood infections. It has been noted elsewhere that long-term health consequences from unsafe abortions can include chronic pelvic pain, problems getting and staying pregnant, infertility, tubal blockage and ectopic pregnancy.[68]

Health workers and health researchers have found similar trends in complications. In 1999, a project conducted by the Family Planning and Population Division (FP&PD), the Department of Health and the Ministry of Public Health in Thailand assessed the situation of abortions in Thailand and found that nearly half of the women seeking medical attention for complications resulting from induced abortions had notably severe conditions such as hemorrhaging, septicemia, peritonitis and/or injury to the uterus.[69] At a meeting in Mae Sot (May 2004) with local health-oriented NGO staff and medical professionals, experiences of working to prevent unsafe abortions and related complications among members of the Burmese migrant community were discussed.[70] Health workers expressed frustration at not being able to reach women who were considering abortion until after they had already had one and were seeking treatment for related complications.

Initiatives that make women aware of unsafe abortion procedures, education programs on the risks of abortions, and benefits/methods of family planning have been implemented, but these

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Referenced in: Planned Parenthood Federation of America. "Unsafe Abortion Around the World - Factsheet." http://www.plannedparenthood.org/library/abortion/unsafeab.html

[68] AbouZahr, Carla & Elizabeth Åhman. "Unsafe Abortion and Ectopic Pregnancy." (267-296) in Christopher J.L. Murray & Alan D. Lopez (eds) *Health Dimensions of Sex and Reproduction: The Global Burden of Sexually Transmitted Diseases, HIV, Maternal Conditions, Perinatal Disorders, and Congenital Anomalies.* Cambridge, MA: Harvard School of Public Health on behalf of the World Health Organization and the World Bank, 1998. Referenced in: Planned Parenthood Federation of America. "Unsafe Abortion Around the World - Factsheet." http://www.plannedparenthood.org/library/abortion/unsafeab.html

[69] Nongluk, Boonthai and Warakamin Suwanna. "Induced Abortion: Nationwide Survey in Thailand." Papers from the Medical Women's International Association – 25th International Congress. Sydney, Australia, 19-23 April 2001. http://mwia.regional.org.au/papers/papers/14_nongluk.htm#TopOfPage

[70] In 1999, at the Mae Tao Clinic, "277 women presented to the clinic with complications of abortion. An alarming 3% were young women under 20 years of age and one out of five had had at least one previous abortion." Maung, Cynthia and Susan J. Purdin. "Reproductive Health Services for Burmese Refugees on the Thai-Burmese Border." *Sexual Health Exchange*. Royal Tropical Institute, Zimbabwe, No.2. 2000.

have had only marginal success. This is primarily due to limitations in reaching women who are in the process of becoming sexually active or are contemplating having an abortion. It was agreed that outreach education and contraceptive dissemination programs must continue to be expanded and that it was essential to go directly to the workplaces of migrants in order to be effective. Training programs for TBAs on the risks of unsafe abortion procedures, including follow-up sessions, were also recommended.

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CHAPTER 6

From Research to Action

Conclusions and Recommendations

The striking finding of both the qualitative and quantitative study was the high degree of agency shown by the women in initiating the process of migration in the hope of a better future and their awareness of risks involved. The research also made it evident that there was very little connection between legal status (obtaining working permit and the permit to stay) and access to health care. Most women reported that available health information often focused on one particular disease such as HIV or malaria but health workers often did not have time or expertise to provide some basic knowledge about how a woman's body works and how to treat symptoms like backache, headache and skin infections. This research has also provided evidence that in the absence of adequate and safe abortion services, women often resort to unsafe abortion. Psychological health is a highly neglected area. While speaking about the pain in their lives, such as domestic violence, sexual assault, physical and psychological abuse, women hoped that the researchers might be able to provide some help and keep up contact and friendship with them.

The researchers felt involved in the situation of migrant women and attempted to create some space for the women where they would be able to relax and engage in some useful activities. The self-help health training was organized in consultation with rights-based health activists and local groups at the research sites. The pilot health training was initially planned for migrants of all nationalities, especially Cambodia and Laos who have limited access to health care. However, it was difficult for them to involve in a training that required a long-term commitment. A month-long training, therefore, was organized only for Burmese migrants in Mae Sot area. The group had seventeen women that included sex workers, factory workers, unemployed housewives and traditional birth attendants. The training in three phases aimed at raising awareness of health care by looking at women's right to health, gender-based violence against migrant women, and the adverse effects of health on their well-being and quality of life. The first training provided basic skills for self-examination of body, identifying disorders, communication and counseling. The participants were encouraged to put these skills into practice by identifying their problems and sharing them with other migrant women in their community and workplace. In the final phase of training, women came to the conclusion that they needed a space of their own to engage in

activities useful to them. Hence, the informal drop-in center was created near the migrant community in Mae Sot for Burmese migrants. The volunteers provide practical health advice to women who come to the center and try to combine their knowledge of traditional herbal medicine with the skills they have attained from the training. In the first year of its operation, the center has accommodated and involved about 1000 women in discussions on reproductive health, domestic violence, health counseling and treatment. The center also conducts regular health awareness campaigns and outreach activities in migrant communities and workplaces, and provides a safe space for migrant women who encounter not only physical health problems but also psycho-social problems. A number of women come to the center to share their problems and seek counseling for domestic violence, forced marriage and child abuse. Women also use it as a temporary shelter if they are in the process of moving out of violent and abusive relationships.

Learning to use a thermometer

It is evident that the formation of the Self-help Group and a center of this kind is one of the most effective strategies to bring about positive changes in the family and at workplace. Admittedly, forming a collective among migrant workers, particularly undocumented migrants who have a high degree of insecurity, is not easy. But experience based on research shows that there is a natural desire among the women to form a group of their own to initiate activities and services pertinent to their needs and conditions. However, their efforts have to be sustained and supported through affirmative policies at the government level and by independent organizations that work with migrant people or have a specific health focus.

Based on the findings of the research, the report makes recommendations at three levels: government and policy makers, health care providers, and organizations working with migrant populations. These recommendations are intended to assist female migrant workers in accessing safe and appropriate reproductive health care.

Recommendations to Government and Policy Makers

- Provide migrants with legal status by liberalizing migration policies, particularly those that govern freedom of mobility and, especially, the legal implementation of the right of freedom from discrimination in access to health care services that impact on both physical and psychological well-being.

- Integrate into the work of the Department of Health and Violence Against Women Program the monitoring, surveillance and treatment of incidents of violence against women in the entertainment industry by clients, police and proprietors.

- Formulate and enforce comprehensive labor protection policies (regarding work hours, fair wages, safety measures) in the informal sector, especially domestic work, sex work and home-based work.

- Provide and implement comprehensive safeguards for employer-provided living accommodations, including mandates of clean running water, decent private space, safe electricity, ventilation mechanisms and maintenance of sanitation levels.

- Provide better protection programs for domestic workers including efficient safety nets, such as residential dormitories and training on prevention and response to sexual harassment from employers.

- Enforce criminal law on slavery against employers to protect the fundamental rights of migrant workers especially of domestic workers.

- Make safe abortion available for migrant women, complemented by an increase in attention to preventive strategies to reduce unwanted pregnancies.

Recommendations to Health Care Providers

- Actively respond in collaboration with NGOs to particular health concerns of migrant women such as trauma, psychological stress, migration-related illnesses/injuries and women's reproductive health. Health care services for migrant women should operate with the awareness that many health-related problems are consequences of violation and exploitation and affect both physical and psychological health. Therefore, health care providers should be trained to incorporate both skills in their services.

- Adopt 'migrant friendly' policies, including use of trained translators, cultural mediators and low-cost treatment.

- Keenly investigate the use of contraceptive methods among migrant women, especially the oral pill. Health care providers should be more careful in distributing the oral pill in the community. The distributions have to be in tandem with consultation and correct prescription. They should also ensure that all communities are able to access condoms. Health service providers should proactively encourage the use of the contraceptives by providing these for a minimal fee or free of charge and establish specific clinics for consultation on side effects.

- Collaborate with and organize training for traditional birth attendants and migrant health volunteers to provide health care services and health education in migrant communities.

- Support the formation of migrant self-help groups to provide pertinent physical, psychological and reproductive health care to migrant workers.

Recommendations to Organizations Working with Migrant Workers

- Collaborate with NGOs and health care providers to actively respond to the particular health concerns of migrant women, as well as to address exploitation and abuse which are the root causes of women's health problems.

- Provide accessible reproductive health clinics and a competent woman translator who is sensitive to women's problems and respects their right to privacy.

- Organize regular outreach programs and health education campaigns in migrant communities and their workplaces.

- Organize programs for educating and sensitizing those who ask for services.

- Encourage formation of women's self-help health groups in communities and workplaces, and enable the groups to provide basic health education to migrant workers and ensure that migrant women workers are able to access existing health care services in their areas.

- Provide basic skills training on health education and health care to volunteers of the self-help group from the respective community and workplace. They should also get support from the local government/NGOs/employers to organize health care activities in their communities and workplaces. Their role should be socially and legally recognized by the local authority.

- Incorporate traditional medical practices and health knowledge into culturally sensitive health trainings and/or medical treatment.

- Institute collaborative efforts to make possible information-sharing between trained doctors and traditional healers (including TBAs).

- Provide on-site, clear and accessible information training for migrant workers regarding benefits and procedures of registration and obtaining a work permit.

Mae Sot Women's Center

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