Cross-border Migration and HIV/AIDS Vulnerability in the Thai-Myamar Border : Sangkhlaburi and Ranong

Supang Chantavanich
Shakti Paul
Amornthip Amaraphibal
Praweenja Suwannachot
Premjai Wangsiripaisal
Allan Beesey

**Asian Research Center for Migration,
Institute of Asian Studies
Chulalongkorn University
Bangkok, Thailand**

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Report Submitted to : The World Health OrganiZation
Bangkok, Thailand
MARCH 2000
Paper Series No./**018**

National Library of Thailand Cataloging in Publication Data

Chulalongkorn University, Institute of Asian Studies.
Cross-border Migration and HIV/AIDS Vulnerability in the Thai-Myamar Border Sangkhlaburi and Ranong.-- Bangkok : Institute of Asian Studies, Chulalongkorn University, 2000.
218 p.
1.AIDS(Disease)--Transmission.
I.Supang Chantavanich, ed, II.Title.

614.599392
ISBN : 974-333-522-6

Author
Supang Chantavanich, Shakti Paul, Amornthip Amaraphibal, Praweenja Suwannachot, Premjai Wangsiripaisal, Allan Beesey
Cover Designed
Sutee Boonla
First Published
February 2000
Price
300 Baht
Publisher
Asian Research Center for Migration,
Institute of Asian Studies
Chulalongkorn University
Office
Institute of Asian Studies
Chulalongkorn University
Bangkok 10330, Thailand
Tel : 251-5199,218-7464-5 Fax (662) 255-1124
http://www.ias.chula.ac.th
Distributed by
Chulalongkorn University Book Center Salaprakiaw Building
Tel. 218-7000, 218-3980,255-4433 Fax. (662)255-4441
e-mail:cubook@chula.ac.th
http://www.cubook.chula.ac.th
Printing
Seven Press and Promotion Co.,ltd
Tel. 981-7702

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Preface

Thailand has experienced considerable emigration flows over the past few decades; however, due to economic growth over that period Thailand has become a receiving country, attracting many migrant workers from neighbouring countries. Since around 1990 the government was faced with growing numbers of migrants and pressure to deal with problems associated with this movement.

Migrant workers can now be found in almost all provinces; however, the economic crisis in 1997 had some impact on the migration streams and the influence of this economic downturn is still being felt as the government attempts to regulate the flow of workers, through new registration of workers and stricter enforcement procedures. The government is responding to increasing unemployment among Thais but employers argue that Thais do not want most of the jobs taken by migrants. The problem of migrants versus Thais is that migrants generally work for very low wages and have no health and welfare support.

There are many issues surrounding workers' rights and the plight of migrants in their hometown, which motivates them to seek greater opportunities elsewhere; they are faced with many difficulties in their destination as well. Health problems and access to services can be a problem but this is now made worse by the increasing prevalence of HIV/AIDS and the unique characteristics of border areas which tend to facilitate the spread of HIV.

Some years following the rapid spread of HIV in Thailand serious epidemics have emerged in both Cambodia and Myanmar where many of the migrants come from, with the greater majority from Myanmar. In many areas of Thailand HIV/AIDS is being competently dealt with, although it remains a major problem, but the same cannot be said for surrounding countries, nor even for some border areas within Thailand.

Border locations have emerged as areas of critical concern in the fight against AIDS in recent years. In 1997, ARCM, with the support of WHO and SEAMEO/GTZ organised the Second on Trans-national Population Movement and HIV/AIDS in Southeast Asia. This followed the First Technical Consultation organised by ARCM in 1995. Migrant and mobile populations have become major agenda items of most international agencies working on HIV/AIDS in the region over the past few years.

It is important that recommendations articulated in this report are accompanied by policy changes that reflect the situation of migrants and resolve to improve the conditions of migrants, especially that of health care. To this end the relevant ministries of Health and Labour and Social Welfare will need to secure the support of international agencies.

เลขหมู่
เลขทะเบียน 012855
วัน, เดือน, ปี 27 ก.ย. 49

Dr Surapone Virulrak
Acting Director, Institute of Asian Studies

Acknowledgements

This situation analysis of migrant people's HIV Vulnerability in the Thai-Myanmar border is a collaborative effort between the Asian Research Centre for Migration (ARCM), Institute of Asian Studies, Chualongkorn University and the AIDS Division, Ministry of Public Health (MOPH), and is supported by the World Health Organisation (WHO) in Thailand.

Many people and organisations in the border areas of Sangkhlaburi and Ranong contributed to the study. We would like to thank Mr. Chang Sukpradit, Dr. Sweoy Sripongwilaiyakul and staff of Sangkhlaburi district health office, doctors and staff of Sangkhlaburi district hospital, Dr. Sakda Netek of Christian missionary hospital, and Mr. Kasauh Mon of the Mon Relief Committee in Sangkhlaburi for their help in data collection and in the conduct of field interviews. In Ranong, we would like to thank staff of World Vision Foundation of Thailand (WVT), Ranong office, especially Dr. Naing and Khun Chuwong Seangkong for their continuing collaboration with ARCM and its works. Dr. Sophon Mekthon, Dr. Somchai Wongcharoenyong of Ranong provincial health office and their staff in the AIDS section of the provincial health office were particularly helpful to the project. Khun Jirwat Tansumet of Ranong Chamber of Industry facilitated the local data collection and work procedures at the local level.

We would like to express our sincere thanks to Dr. Vichai Poshyachinda of the Institute of Health Research, Chulalongkorn University and Dr. Wiput Phoolcharoen, the Director of the Health Systems Research Institute of the Ministry of Public Health, who was the Director of the AIDS Division when this study was in progress, and his colleagues at the AIDS Division for their insights in developing the design and methodological approaches. Our thanks go to Dr. E. B. Doberstyn, WHO Representative for Thailand and Khun Laksami Suebsaeng of WHO for their continuous support of the project. Dr. Nonglak and Dr. Suchada Bowarnkitiwong from the Department of Educational Research, Faculty of Education at Chulalongkorn University who kindly gave advice on sampling design and statistical analysis of data.

Our heartfelt thanks go to the local interview teams in Sangkhlaburi and Ranong who have done a tremendous job in identifying target groups and conducting interviews in difficult circumstances. They have been particularly helpful to make contact with the key informants and making arrangements for cross-border interviews.

Within ARCM, Dr Supang has been the strategist and co-ordinator of the study. Ms Premjai Wangsiriplasisal acted as the main field investigator. Dr Shakti Paul has done the situation analysis and writing of the report. Ms Amorntip Amaraphibal has contributed in the statistical analysis of data. We would like to thank all ARCM staff who have assisted in this project especially, Dr Andreas Lamerz for editing, Ms Tharin Clauwat for the maps and Mr Suthee Bunla for the cover design.

Above all we would like to thank all Cambodian migrants at Aranyaprathet and Khlong Yai for their cooperation and participation in the quantitative survey and in the focus group discussions and in-depth interviews. Without their cooperation this study would not have been possible.

Table of Contents

Preface *i*
Acknowledgement *ii*
Abbreviations *iii*

Executive Summary 1
Chapter I: Introduction, Objectives and Methodology 11
Chapter II: Conceptual Framework 21

Chapter III: HIV Vulnerability at Sangkhlaburi
3.1 Background Information 32
3.2 Health Situation and Services 40
3.3 HIV/AIDS Situation 44
3.4 Methodological Issues 46
Study Findings on Migration Pattern
3.5 Demography of Study Sample 48
3.6 Migratory Experience 53
Study Findings on HIV/AIDS Risk Situations
3.7 Knowledge of HIV/AIDS/STDs 71
3.8 Attitudes and Beliefs of Sexual Behaviours 84
3.9 Attitudes to People Living with HIV/AIDS 86
3.10 Risk Situations and Risk Behaviours 88
3.11 Health Seeking Behaviour and HIV/AIDS Services 95
3.12 Summary and Specific Recommendations 98

Chapter IV: HIV Vulnerability at Ranong
4.1 Background Information 107
4.2 Health Situation and Services 112
4.3 HIV/AIDS Situation 115
4.4 Methodological Issues 118
Study Findings on Migration Pattern
4.5 Demography of Study Sample 119
4.6 Migratory Experience 125
Study Findings on HIV/AIDS Risk Situations
4.7 Knowledge of HIV/AIDS/STDs 143
4.8 Attitudes and Beliefs of Sexual Behaviours 155
4.9 Attitudes to People Living with HIV/AIDS 157
4.10 Risk Situations and Risk Behaviours 158
4.11 Health Seeking Behaviour and HIV/AIDS Services 172
4.12 Summary and Specific Recommendations 175

Chapter V: Summary of Thai-Myanmar Border Situations
5.1 Conclusions and Comparison of Sangkhlaburi and Ranong 188
5.2 General Recommendations 193

References *196*
Appendix: Questionnaire *201*

Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARC	American Refugee Committee
ARCM	Asian Research Centre for Migration
ARV	Anti-retroviral Therapy
BBC	Burma Border Consortium
CARE	Charitable American Relief Everywhere
CBO	Community Based Organisation
CMH	Christian Missionary Hospital
CSW	Commercial Sex Workers or Sex Workers
EPI	Expanded Programme for Immunisation
FHI	Family Health International
GO	Governmental Organisation
GTZ	Deutsche Gusellschaft fuer Technische Zusammenarbeit
HIV	Human Immuno-deficiency Virus
IDC	Immigration Detention Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPD	In-patient Department
KAP	Knowledge, Attitude and Practice
MCH	Maternal and Child Health
MCT	Mother-to-Child Transmission
MCWA	Maternity and Child Welfare Association (Myanmar)
MLSW	Ministry of Labour and Social Welfare (Thailand)
MOPH	Ministry of Public Health (Thailand)
MSF	Medicins Sans Frontieres
MSM	Man Who Have Sex With Man
NGOs	Non-governmental Organisations
OPD	Out-patient Department
PATH	Programme for Appropriate Technology in Health
PLA	Participatory Learning and Activities
PWHA	People Living With and Affected by HIV and AIDS
SEAMEO	Southeast Asian Ministers of Education Organisation
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organisation
WVM	World Vision Myanmar
WVT	World Vision Foundation of Thailand

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

CROSS-BORDER MIGRATION AND HIV VULNERABILITY IN THE THAI-MYANMAR BORDER: SANGKHLABURI AND RANONG

EXECUTIVE SUMMARY

Background and rationale

Over the last two decades rapid economic growth in Thailand has increased its demand for migrant labour, many of whom come from Myanmar but also Cambodia, China and Laos. Usually the migrants are employed in the labour intensive jobs which are often shunned by Thai labourers e.g. fishing, fish related, agriculture and plantation, construction, rice mills, retail and domestic services etc. At present, migrant workers can be seen in most of the provinces of Thailand, even though their numbers have reduced due to the current economic crisis and stringent law enforcement. In addition to the migrant workers, border areas have become magnets for many mobile people including traders and businessmen, and general commerce which brings many truck drivers into the areas. There are increasing numbers of tourists in some border areas, and often a large presence of police and military. Criminal gangs have been known to operate in many of these sites and the local areas have been sources of, and transit points for, trafficking in drugs, in women and girls for prostitution, and for smuggling a range of goods.

This study is part of a series of studies ARCM is undertaking at eight border locations with Myanmar, Cambodia and Malaysia with the funding support from WHO Thailand, UNAIDS Thailand and Ministry of University Affairs, Thailand. Other study sites are Mae Sot (Tak), Mae Sai (Chiangrai), Aranyaprathet (Sakaew), Khlong Yai (Trad), Sadao (Songkhla) and Sungai Kolok (Narathiwas). The main objectives of these studies are to provide local and national level service providers, policy makers, donors and international agencies with critical information and contextual analyses to improve health care services of the migrant population including HIV/AIDS/STDs programmes in these areas or elsewhere in the region.

The study used both quantitative and qualitative methods. Quantitative data are collected by structured questionnaire and interviews on migration process, and knowledge, attitude and behaviour on HIV/AIDS. In addition, qualitative research using key informants interviews and focus group discussions were used to collect background information and to support the interpretation and analysis of quantitative data. Relevant secondary data was collected from local health and government offices and NGOs as well as other research and programme reports.

The report has five chapters. Chapters one and two covers introduction, methodology and conceptual framework. Two major chapters (three and four) one each for Sangkhlaburi and Ranong describes the migration process and HIV/AIDS risk situation at the location. Each of the chapters three and four ends with a summary and specific recommendations for the particular site. Finally, chapter five provides a short review of the Thai-Myanmar border, comparison between two study sites, and then provides some general recommendations that are applicable to other border areas beyond just these two locations.

Key findings in Sangkhlaburi

Migration Situation

1. An estimated 20,000 migrants exceeds 11,606 local Thai population in the district. Ethnically, most of them are Mon (43%) and Karen (36%) with small number of Burmese (16%) (see section 3.5).

2. About half (51.5%) of the respondents have lived in Sangkhlaburi for over five years (section 3.6) and many of them have pink, orange and blue immigration cards (section 3.6). 65% do not intend to return to Myanmar but wish to live permanently in Thailand.

3. Another group of migrants gather at some locations inside Myanmar (e.g. Japanese Well) and travel to central Thailand. These people are transitory and do not intend to live in Thailand. Thousands of refugees in the border camps also intend to return to Myanmar.

4. About 39% of the migrant workers are women (section 3.5). In addition there are many housewives who accompany their husbands and families and do not have any formal job. In general, women have low socio-economic status and lower knowledge of HIV/AIDS. These combined factors make them vulnerable to HIV/AIDS transmission.

5. Agriculture is the main occupation which employs up to 58% of the migrants (section 3.5). Others are labourers, service/maids, fishermen and construction workers. Overall agriculture workers and fishermen have very low knowledge of HIV/AIDS.

HIV/AIDS Risk Situation

6. Knowledge of HIV/AIDS among migrants in Sangkhlaburi is very low (mean = .4054) (section 3.7) which vary from groups to groups. Predominantly Mon Buddhists have less knowledge than Karen Christians.

7. There is a very small commercial sex industry with about 20-25 indirect sex workers. Most of their clients are Thai uniformed men and officials, traders, truckers and some wealthy residents who are vulnerable to HIV. Only a few migrants visit these places

8. Overall 22.5% of the respondents had casual sex within the last year. Both single and married men are more likely to have sex with married and divorced women (section 3.10). Condom use is very low in the population. It is sometimes used (12.5%) in casual sex and almost never in regular partner sex.

9. Misperceptions of HIV/AIDS is very common in this population (sections 3.7 - 3.9) which in addition to their HIV vulnerability contributes to the negative attitude towards PWHAs.

10. Eleven or 3.4% of the respondents (eight men and three women) have reported injecting drugs and six of them shared needles. In addition, 15% of the respondents have used some injections for the treatment of their illnesses in the last year.

Health and HIV/AIDS Services

11. 88% of the respondents know about health services in Sangkhlaburi and most of them go to government hospital and clinics. Some migrants and refugees visit the Christian missionary hospital which in addition to general services provide special care for the physical and mentally disabled people as well as PWHAs.

12. MSF and ARC are NGOs involved in the health services of the refugees in the camp including deported or repatriated migrants from Thailand. They act as a bridge between both sides of the border and are an important link with Mon and Karen inside Myanmar.

Key findings in Ranong

Migration Situation

1. An 77,500 migrants in the Muang district of Ranong slightly exceeds the 73,361 local residents. Ethnically, most of them are Burmese (57.7%) and relatively smaller number of Mon, Tavoy and Karen (section 4.5).

2. About half (48.8%) of the respondents have lived in Ranong for over three years including 27.4% more than five years (section 4.6). Almost all migrant intend to return home after they have saved some money to begin a new life in Myanmar.

3. About 38% of the migrant workers in Ranong are women (section 4.5) employed in various occupations including sex work and in entertainment venues. In addition, there are many housewives who accompany their husbands and families and do not have a formal job.

4. Overall women have lower socio-economic status in the migrant community and lower knowledge about HIV/AIDS than men. These combined factors make them vulnerable to HIV/AIDS transmission (section 4.7).

5. Illegal status of migrants is a major problem in Ranong. Because of this they become a constant target of police crackdowns, arbitrary treatment by the employers, improper workers benefits, and difficulty in accessing health services.

6. Fishing is the dominant industry in Ranong that employs about 35% of the migrants (section 4.5). Many others work in fish related industries and water transport. Service, agriculture, manufacturing, construction and sex work are other occupations.

HIV/AIDS Situations

7. There is a very large sex industry in Ranong comprising of up to 500 mostly indirect sex workers (section 4.10). A great majority of them are from Myanmar and mainly cater to their own countrymen but also some Thai and foreign clients.

8. Single men are likely to be involved in casual and commercial sex than married and divorced men (section 4.8). Divorced women are more likely to have casual sex and be involved in commercial sex. Casual sex also occurs with married and single women.

9. Due to a complex network of regular partners, casual and commercial sex among migrants (section 4.10), a large number of people are vulnerable to widespread transmission of HIV/AIDS not only in the particular risk groups but the general population as well.

10. Among various occupational groups, fishermen, fishery related and sea transport workers are more likely to visit sex workers. Those who drink alcohol and go to entertainment venues are more likely to visit sex workers.

11. There are a number of Thai population groups who are vulnerable to HIV/AIDS e.g. fishermen, truckers, traders and tourist and visitors. Some local people also patronise sex workers including migrants that make them vulnerable to HIV.

12. Condom use is very low in this vulnerable situation (section 4.8). It is still lagging behind in commercial sex (60%), sometimes used in casual sex (30%) and rarely in regular partner sex (2%). Availability and cost are cited as the main reasons for low use.

13. Because of existing WVT project activities, sex workers and fishermen have high knowledge of HIV/AIDS which is yet to make significant change in their risk behaviours (section 4.7 and 4.10). They are more likely to have unsafe sex and use drugs than any other groups. Construction workers have significantly low knowledge of HIV/AIDS.

14. Misperceptions of HIV/AIDS is common in this population (section 3.7) which in addition to their HIV vulnerability, contributes to the negative attitude towards PWHAs.

15. Lack of alternative recreational opportunities is often cited as the main reason for high risk behaviours. But the study found that peer pressure and complex socio-economic situations are the cause of frequent drinking, commercial and casual sex, and drug use.

16. All in all, people with better knowledge of HIV/AIDS have better attitude PWHAs. Better knowledge also helps to develop better attitude towards sexual behaviours and acceptable norms e.g. more inclined to disagree with casual and commercial sex.

Health and HIV/AIDS Services

17. Access to health care at the Thai hospital is a problem for many migrants in Ranong. Illegal status, language barriers and high cost of treatment make it difficult for getting services. Usually they seek services in the hospital as a last resort when everything else fail.

18. WVT clinic provides OPD care and its outreach programme supports primary health care including HIV/AIDS services in six migrant communities (population 15,000). While the project has been successful and it is vital for service provision to migrants it needs to address some of the following major issues - (i) constant dependence of the project for outside funding, (ii) lack of private sector i.e. employers of migrants' involvement in the

care of their employees, and (iii) need for expansion of similar activities to the remaining 62,500 migrant people in the district who live outside WVT assisted communities.

19.Private sector businesses that employ migrant workers are not involved in the health care and social welfare/security of their employees. But some of them are showing interest to support these activities, which should be pursued at all levels, such as the Thai Myanmar Fishery Co-ordination Centre and Saphanplar State Enterprise, boat and pier owners etc.

Comparison between Ranong and Sangkhlaburi

Chapter V provides a detailed comparison of the migration and HIV/AIDS risk situations, and health and HIV/AIDS services in Ranong and Sangkhlaburi which illustrate the unique situations at each border crossing. Population migration is very dynamic in Ranong involving a very large number of people i.e. about 77,500 in Muang district. In addition, thousands of others stay a short time in Ranong and then travel to central and southern Thailand. So this is a mixture of both transient and stable migrants. In comparison, in Sangkhlaburi there are about 20,000 migrants in the district. About 15,000 Mon and Karen refugees in several of the camps along the border. There are also some migrants who travel from border locations to central Thailand. Many of the latter group are arrested en-route or at the destinations by Thai authorities and deported back to the border. So in general, migrants in Sangkhlaburi are not too much involved with the transitory migrants and live in the stable communities in and around Thai villages. It is also a fact that the Mon and Karen have closer cultural links with Thai people and often receive favourable treatment in Thailand. The predominantly Burmese migrants in Ranong have historical and cultural differences with Thai people and they usually receive a cool reception from the authorities. As a result, the migrants in Ranong tend to live in the 'patchy' migrant communities clustered in the overcrowded port area.

There is a significantly contrasting picture of HIV transmission in Ranong and Sangkhlaburi. In Ranong there are two main patterns of HIV transmission - (i) rapid transmission through commercial sex among sex workers and their clients, and IDUs, and (ii) slow transmission among general population through casual and regular partner sex. While the former had a very prominent role in the transmission of HIV in the past and still do to a large extent, the latter have become increasingly important in the transmission in the present circumstances. In another words, the extent of 'unsafe' casual and regular sex are sufficient to keep the momentum of HIV/AIDS epidemic going on for some time. So it is important that any existing and future HIV programme in Ranong addresses both of these transmission patterns. In comparison, Sangkhlaburi has a relatively small commercial sex industry and most of their clients are Thai officials, traders and wealthy local residents. Few migrants can afford to visit such places. However, a significant number of migrants are involved in 'unsafe' casual sex among themselves, sometimes with the migrants from other places and so on. There are also some IDUs in the migrant community. So it can be concluded beyond doubt that there is a slow HIV transmission in this population and so many will certainly be at risk. This finding is also supported by the limited HIV testing data available from the local hospitals. So HIV prevention programmes should begin in these communities without any further delay and hopefully the situation can be contained at this early stage.

Specific Recommendations

The main purpose of this study is to provide an analysis of the HIV/AIDS situation of migrant and mobile populations in Ranong and Sangkhlaburi. In making recommendations one should bear in mind that the migrants live, work and interact with the Thai people, their employers, health staff and police, immigration and other government officials who understand very well about their local situations, organisational capacities and available resources. It is therefore that the following recommendations should be viewed as a guide for discussion with the local and national working committees to develop strategies for intervention programmes in the areas (see recommendations in sections 3.12 and 4.12):

1. **Formation of a "local working committee" for migrant populations:** In Ranong and Sangkhlaburi, "local working committees" should be set up to co-ordinate activities related to the migrant workers. The main purpose of these committees will be to develop and/or improve health services including HIV/AIDS for the migrant population. These committees should include but not be limited to representatives of the migrant community, government agencies such as police and immigration, health, labour and social welfare offices, NGOs and civil society groups. The committees should have some degree of autonomy to deal with local issues and should be allowed to raise local funding and use it for local purposes, and implementing necessary cross-border collaborations at the local level. The committees should be linked with and receive support from provincial and central policy making bodies.

2. **Organisation of a local workshop:** As an initial stage for the formation of the proposed local committees as indicated above, meetings and workshops should be organised in Sangkhlaburi and Ranong involving all potential participants. The workshops should discuss the findings and recommendations of this study as well as the structure, functions and funding of the proposed committee. The committees and their partner agencies should then prepare detailed work plan and implementation roster of their activities. These meetings will also be an important first step for the dissemination of the information to the local audiences.

3. **Migrant People and community level:** Many migrants have been living in Sangkhlaburi and Ranong for several years and are concentrated in the migrant communities. Baring some short-comings, these communities have developed some systems of community organisations and activities with or without outside assistance. Lessons learned from these community level activities as well as general strength of the communities could serve as a valuable asset for the strategies and approaches to the community level responses. Some specific recommendations for the community level activities are (see details in sections 3.12 and 4.12) -

- Peer education programme
- Community mobilisation
- Targeted interventions
- Focus on life-skills
- Gender sensitive approach

4. **Public health services:** It is acknowledged that the government health services have limited human and financial resources to deal with such a large number of migrants.

Language barriers, hiring of local staff, budgetary deficiencies are just a few examples of their difficulties. In consultation with the local committees, the public health department should develop plans to resolve some of these issues through public-private mix management. For example, they may raise local fund by introducing health cards or social security schemes for the workers, and funds could be used for such things as hiring local bilingual interpreters through NGOs or the private sector (WVT or Saphanplar Enterprise in Ranong, and missionary hospital, MSF or ARC in Sangkhlaburi).

5. **NGOs programme:** WVT has been very active with the provision of services for the migrants in Ranong. In addition to running a clinic, they have done an effective job in facilitating the organisation of community level activities. Because of instability within the migrants' communities, they require constant supervision and readjustment. The following suggestions are made to improve efficiency and sustainability of the project - (i) in consultation with public health office and local committee, transfer the administrative responsibilities of clinic from the government to the private sector. This will help to develop local management and financial systems for its self-sustenance, (ii) in consultation with the local committee and private sector (e.g. Saphanplar State Enterprise) develop an alternative private management system as suggested above. Involvement with private sector will also help for better working relations with the migrant workers and their communities (details to be worked out locally), and (iii) in consultation with the local committee develop and implement a plan for the expansion of services to the other migrant populations in the district.

In Sangkhlaburi, CMH and other NGOs may work with the migrant communities for the training and supervision of peer educators, targeted interventions with the sex workers etc.

6. **Employer/private sector involvement:** Almost all migrant workers are employed in the businesses and industries run by the private sector such as fishing companies, production industries, construction companies, restaurant and entertainment owners. They should be actively involved in the discussions for health care strategies of their workers. In any such discussion with them one should be keep in mind to clarify that while profit-making for their individual business is their priority, human rights issues do not necessarily detract from this (see details in section 3.12 and 4.12). Some of their possible involvement are outlined in the NGOs section above.

7. **Integration, not compartmentalisation of programmes**: The study identifies specific vulnerability of some migrant population groups. But any effort to promote HIV prevention in this populations should disassociate HIV infection from at-risk groups and focus on their risk situations. It means that programmes may still target those particular groups but careful attention should be given in the 'targeting process' that focus on their behaviours, and ensure that the groups are not further stigmatised by the programme. As a way to avoid such critical issues it is desirable to develop programmes that address several population groups at the location and develop a dialogue and cooperation among them.

8. **Cross-border collaboration between the opposing border towns:** There are some areas where cross-border collaboration could be very useful in Ranong and Sangkhlaburi. However, such an approach should be as practical as possible so that the issues can be dealt effectively at the local level. Some of the existing and possible future collaborations are – sharing information of communicable diseases including HIV/AIDS, development of IEC

materials, and patient referral. Joint planning involving both sides of the border could be an ultimate goal but should only be pursued after small 'pilot' collaborations have proved successful. Cross-border collaboration should not be overemphasise at this stage but instead pursuing a strategy for finding the right time and opportunities and in the process building trust and confidence among agencies working on both sides of the border.

9. **Collaboration with the places of origin and destination of migrants**: Many problems that the migrants face in Ranong and Sangkhlaburi are due to inaccurate information they receive before their departure. It will be very useful to explore the possibility of setting up programmes to disseminate information including HIV/AIDS to the potential migrants in Myanmar before they depart home. The scope of such programming may be limited only to areas with large numbers of emigrants. In this approach the agencies in Myanmar will have the full range of information about problems in Thailand. In addition, they should also assess the needs and opportunities for projects to support the communities including PWHAs in the area.

10. **Formation of national committee on migrant population**: Similar to the provincial committees, a multisectoral committee should be formed at the central level to discuss the health and HIV/AIDS among migrants and in the border areas. Possible functions of the proposed committee are to develop strategic planning, technical support and fund raising for the projects to be implemented at the local level. This committee should also deal with the national level authorities to develop necessary policies on health care services for the migrant populations. Policies should be clear, precise and practical so that they are easy to implement at the provincial and district levels. These policies should become an integral part of the overall policies on migrant populations in the country.

General Recommendations

The following are some of the recommendations that in addition to their relevance to the study sites have much wider implications for other cross-border locations, and for the development of national level strategy and co-ordination of intervention activities. In other words, these recommendations are based on looking at a broader scope than just these study sites, exploring influences and outcomes that have wider application.

1. **Improving legal status:** Illegal status of the migrant workers is one of the main obstacles to the development of health services for the large majority of migrants in Thailand (section 3.11 and 4.11). This affects their access to health care, social network with fellow migrants and local Thai population as well. Because of this, they also do not invest for the long-term benefits and are not so interested to contribute to the development of their communities. Thai government should take concrete measures to regularise migrants' registration and employment conditions including provision for health care and social support system through social security or health card scheme as appropriate. Once a set of clear policies are developed, they should be enforced vigorously to give full benefits to the employers who abide by them. Without a clear policy on migrant labour and improvement of their legal status, it is almost impossible to develop stable and satisfactory services for them in the country.

2. Creation of an 'enabling environment': Cross-border locations often have their unique administrative and economic power structures. Local immigration and border police, military and the governor's office play a crucial role in determining the status and treatment of the migrants in their area. In most instances, these local officials may have 'privileged knowledge' and perhaps interests in some local businesses including commercial sex and drugs. With their tacit support migrant sex workers are brought or trafficked into the venues. Some local officials are also known to patronise them quite regularly. So in the guise of doing their job to solve problems they actually become part of it. It is therefore of utmost importance that these law enforcing authorities be brought to the tasks so that they work with the health department, NGOs, private sector and civil society to create an enabling environment in support of the migrants. While this may appear to be a very far reaching strategy, it however is expected to provide sustainable results in the long run and should therefore be tried in a few 'pilot' sites.

3. Developing monitoring and evaluation tools for border programmes: Border programmes are usually expensive because of geographical remoteness of the areas as well as extent of resource mobilisation required. Unlike HIV/AIDS programmes with native stable communities in a country, these programmes deal with mobile populations and/or relatively unstable communities. There has been considerable debate as to what to expect from the border programmes or to be precise what are the monitoring and evaluation indicators one should use to measure the progress in the projects. With the help of some findings of this study, some additional research may be necessary to develop such monitoring tools.

3. Public Health Services: Government health services have limited resources to cope with large numbers of migrants. Migrants face language difficulties, relatively high costs, and for other reasons the quality of service is often inadequate. In consultation with the local and national committees the public health department should examine these issues and seek solutions. As stated above there must be systems in place to provide basic health services to all registered migrant workers. This could be undertaken by raising local funds through health cards or a social security scheme for registered workers. Funds could support such activities as hiring local bilingual interpreters seconded from the NGOs or the private sector to work in hospitals or public health facilities.

4. Programme for vulnerable Thai populations: MOPH should take a note of the Thai uniformed men, local officials' and other people's involvement in the commercial sex industry in the border areas. In some border locations, mobile Thai people such as truck drivers, fishermen, traders and tourists and visitors are the main clients in commercial sex and perhaps drug use. Public health offices and local committees should develop appropriate awareness and prevention programmes for these vulnerable people especially uniformed men as well the sex workers who provide services. In dealing with the non-Thai speaking Myanmar sex workers, it might be useful to involve NGOs or teh private sector with trained multilingual staff.

6. Mass media programme for the border population: Many local and migrant people in the border areas do not have a clear knowledge of the disease and health risk they are facing. For example Thai traveller or visitors going to Ranong may be exposed to malaria or filariasis. On the other hand, Burmese migrants coming to the border may be exposed to HIV/AIDS/STDs, accidents or violence. It will therefore, be an important step to initiate

good mass media programme such as television and radio programmes, to disseminate information to people on both sides of the border. As a part of the proposed mass media programme, local and national committees on migrant labour should also brief and guide national and international media for proper reporting on sensitive issues involving migrant populations.

7. **Advocacy for the migrant workers:** The local and national committees (see site specific recommendations 1& 2) should raise awareness about migrant and mobile population issues with government officials, NGOs, mass media and the general public. They should provide detailed facts about migrant workers role in the local and national economy and their social consequences. In this way they could contribute to the development of a positive environment about the presence of migrants in the country and help to alleviate some of the existing negative images about them.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

CROSS-BORDER MIGRATION AND HIV/AIDS VULNERABILITY IN THE THAI-MYANMAR BORDER: SANGKHLABURI AND RANONG

CHAPTER I

Introduction

Over the last two decades rapid economic growth in Thailand has effectively transformed the country from a labour exporter during the 1970/80s to a *de facto* labour importing country by early 1990. Since then thousands of migrant labourers from neighbouring countries have been entering Thailand in search of better paid jobs. Most of them are from Myanmar with relatively smaller numbers from Cambodia, China, Laos and South Asian countries. Migrant workers can be found in most provinces of Thailand, even though numbers have reduced due to current economic crisis and stringent law enforcement of border areas. Migrants may come from border provinces which entails limited travelling; however, most travel from more distant provinces to the border area. For many the border area is their destination, others transit through border areas on their journey to and from their destination sites further inside Thailand.

Borders are magnet for many people and one of the most important groups, both due to sheer volume and socio-political implications, are migrant workers. In many sites on the Myanmar border, as well as on the Cambodian border, migrant workers comprise the largest mobile population group. However, border areas are magnets for many mobile population groups, including traders and businessmen, and general commerce which brings many truck drivers into the areas; in addition there are increasing numbers of tourists in some border areas, and often a large presence of police and military. Criminal gangs have been known to operate in many of these sites and the local areas have been sources of, and transit points for, trafficking in drugs, in women and girls for prostitution, and for smuggling a range of goods and artefacts.

Border locations have become of critical concern in recent years in the fight against AIDS. In 1996 with the support of WHO and SEAMEO/GTZ, ARCM organised the Second Technical Consultation on Trans-national Population Movement and HIV/AIDS in Southeast Asia. This meeting followed ARCM's first technical consultation in 1995. In the past couple of years mobile populations and border-crossings have appeared on the agenda of most international organisations involved in HIV/AIDS prevention and care. In 1997 ARCM conducted a rapid assessment of HIV/AIDS along the Thai-Myanmar border and has followed this up with in-depth studies of all the key border crossings in Thailand with the exception of the Thai-Malaysia border, which is currently being planned. From the research conducted and the available epidemiological data it is clear that the Thai-Myanmar border and the Thai Cambodia border contain sites that are among the most riskiest border areas in the Greater Mekong and Southeast Asian region.

HIV has spread well beyond Thailand's borders and the two most badly affected countries are Thailand's near neighbours, namely, Myanmar and Cambodia. The borders are long and

porous, particularly the long stretch of land and rivers that divide Thailand and Myanmar, a length of 2400 km; but even the border that divides Cambodia and Thailand stretches to 798 km. The estimations of HIV infection in Cambodia now give it a great per capita rate of infection than Thailand and the rest of Asia. While IDU has helped in spreading HIV in Thailand the rapid spread has been overwhelmingly due to heterosexual sex. This is the situation in Cambodia where a thriving sex industry is fuelling the rapid rate of HIV spread. In Myanmar, depending on the location, both heterosexual sex and IDU are responsible for the spread of HIV.

Despite the rising incidence of HIV in these two countries the majority of migrants entering Thailand are coming from rural areas that have a relatively low prevalence of HIV/AIDS. This study is concerned with determining the vulnerability of the migrant population in Thailand to HIV infection. In the context of the specific border locations, and the trade and commerce and other activities that occur in the area, this study focuses on the migrant population segmented into occupational groups. The study encompasses the background and migratory process plus current working and living conditions of the migrants, as well as their knowledge and awareness of HIV/AIDS, and their risk behaviours. In addition, the study explores health seeking behaviour and provision for HIV/AIDS prevention and care for migrant populations. The following section looks at the HIV/AIDS situation in more detail.

HIV/AIDS Situation in Thailand

Thailand was the first country in Asia to experience an AIDS epidemic and northern Thailand remains one of the most affected areas in Asia. HIV was detected 15 years ago in Thailand and the epidemic proportions were detected in sex workers in the north 11 years ago, in 1988. Reductions in the rates of infection in the north were detected in 1994/95 and since then the country as a whole has experienced a decline in new infections. Early prevention programs by the government, local NGOs, and international agencies are seen to be responsible for this dramatic decline. Concerted efforts to raise awareness among special groups, and in the community generally, resulted in behaviour modification within many sectors of society.

The incidence is reducing nationally largely because of dramatic reductions in the rapid spread of HIV experienced in the north in the early 1990s. In other parts of Thailand there is a gradual increase in the incidence of HIV. Furthermore, tens of thousand of people are developing AIDS and need to be taken care of. The resources needed for maintaining prevention methods and caring for the huge numbers falling ill and dying is stretching the resources of the Thai government, especially at a time of economic insecurity.

There are now more than one million people infected in Thailand. This is almost 2.5% of the adult population. Over 260,000 people have died since the beginning of the epidemic including 60,000 in 1997. HIV sentinel surveillance in 1998 showed that 1.49% of pregnant women are HIV positive compared to the peak of 2.29% in 1995; and 21.05% of the direct sex workers are positive in 1998 compared to a high of 33.15% in 1994. The trend is almost similar to other sentinel groups with the exception of IDUs who have a consistently high infection rate of 47.46% in 1998. During this period, almost all national HIV/AIDS program have targeted the Thai population. Very few program have included migrant populations in their project even though they constitute a significant proportion of the adult population in the

country. At this time however, migrants cannot be ignored, for they are vulnerable to HIV infection and they may, along with other mobile groups, spread HIV across borders.

HIV/AIDS Situation in Myanmar

Recent UNAIDS/WHO report puts the estimated number of people living with HIV/AIDS in Myanmar as 440,000 at the end of 1997. This is 1.79% of the adult population which is a serious situation indeed considering the first reported HIV case at the country in 1991. The same report indicates an estimated 100,000 cumulative AIDS cases including 86,000 deaths of whom 29,000 died in the year 1997. National sentinel surveillance data of September 1998 shows that 1.79% of pregnant women, 29.8% sex workers and 61.9% IDUs are HIV positive. A WHO/Ministry of Health report in 1997 showed very high prevalence of HIV/AIDS along its eastern border with Thailand, China and Laos compared with the western border and central region. For example, relative-risk of HIV infection in pregnant women at the eastern area was eight times more than that in the western region. Injecting drug use (IUD) has been identified as the primary cause of HIV transmission in the upper northern border with Thailand and that with China. Almost simultaneously, heterosexual transmission started all over the border region with Thailand primarily through unsafe commercial sex. Both of these situations still exist but the epidemic has now spread to deeper inside Myanmar in the main cities and particularly the places of origin of many migrant and mobile population in the country. No precise HIV surveillance data are available to make a full analysis of the epidemiological pattern of the disease.

In this report data on the four sites is given for populations on the Thai side where reliable sentinel surveillance data and other prevalence data has been recorded for several years. Some prevalence data is also given for the other sides of the border as well as data on prevalence on registered migrant workers. Some data shows particularly high rates of HIV prevalence among pregnant women, sex workers and fishermen.

Registration of 'Undocumented' Migrant Workers

The number of migrant workers, especially from Myanmar but also from Cambodia, have rapidly increased over recent years as the economy surged in Thailand and remained relatively stagnant in the two aforementioned countries. In 1999 the Thai government estimates that there are more than 500,000 migrant workers in the country, mostly from Myanmar (Ministry of Labour and Social Welfare, 1999). This is down from estimates of one million in 1997. From this estimate of one million it was determined that registered migrant workers constituted only 29.3% of the total number of migrant workers (Paul S. 1997).

In September 1996, the Thai government issued a directive for the registration and subsequent issuance of temporary work permits for undocumented migrant workers. This followed two previous failed attempts in 1992 and 1994 to regulate the flow of undocumented migrant labour flow into the country. During this last round, the migrants from three neighbouring countries namely Myanmar, Cambodia and Laos were allowed to register. Out of total 76 provinces in the country, 43 were permitted to register. This geographical area possibly covered a great majority but certainly not all of the workers as undocumented migrant workers are present in almost all provinces of the country. The migrants in eight occupations were authorised to register i.e. construction, fisheries, fisheries

related industries (pier work, fish categorisation, cleaning seafood etc.), industrial production (shrimp paste, fish sauce, squid drying, tapioca, lumber rice and pebbles), agriculture, mining, land transportation and domestic helpers. But many others were not allowed to register e.g. garment and shoe factories, restaurants and other service sector, gasoline station, retail shops etc. Prostitution is (officially) illegal in Thailand and therefore, all direct and indirect commercial sex workers (CSWs) as well as entertainment workers were not also registered.

As of April 30, 1997, out of 733.640 workers only 293,652 persons or 40.58% received work permit. Among the registered workers 87.35% were Burmese followed by 8.71% Cambodians and 3.95% Laotians. Migrants were heavily concentrated in the border areas with Myanmar, as well as in Bangkok and near vicinities. Occupation of registered labourers were as follows: construction 34.4%, agriculture 26.6%, domestic helpers 11.6%, fisheries 11.6%, production industries 7.6%, fish-related industries 6.6%, land transport/porter 1.04% and mining 0.6%. However, the above breakdown by occupation may alter significantly if the analysis is based on all migrant labour in the country.

Since the economic crisis occurred hundreds of thousands of migrants have been sent back across the border. Given that it is not difficult for them to return at many points along the border, or even at official crossings, many have come back. One of the government's main concerns with the migrant workers was that they may be taking jobs that Thais, who have become unemployed due to the crisis, could undertake. However, it has been demonstrated that there is a continuing demand for mainly unskilled labour, and much of it work that most Thais do not want to do.

The government recently decided that the registration program will continue and workers have been given a three month extension, or grace period, to register again if their job is included in the continuing program. If their occupation or their particular work place is not included they will be repatriated. The government is deciding which provinces and which industries will be included in the continuing program.

The estimations of migrant workers does not include family members - women and children - which are unusually high among migrant populations in Thailand. Women also make up a substantial proportion of migrant workers, which is reflected in the numbers of registered workers, as presented in Table 1 there were over 75,000 female registered workers in 1997.

Table 1: Migrant Labourers by Gender in Thailand

MALE	FEMALE	TOTAL
178,889	75,820	254,709
70%	30%	100%

Data source: Ministry of Public Health (37 provinces during health check-up for the registration in 1996-97)

Migrant and Mobile Populations in Border Areas

Migrant workers include those who work in border regions, as is studied in this report, and those who transit through border regions to go further inside Thailand. Many travel to such

places as Bangkok and other major cities, or port areas, or farming areas and plantations. Many who travel further into Thailand may migrate for longer periods of time. They may face the difficulty of not finding work, which has occurred during the economic crisis, and thus need more financial resources to sustain themselves in their travels (Sophal 1999). Those who work close to the borders are less likely to deal with agents or guides and need fewer resources for travelling. On the border they may work seasonally and return home after relatively short periods but on the other hand many stay for longer periods of time.

Migrant workers are a substantial part of border populations at any one time, however, as borders are focal points for trade and commerce, as well as illicit trade and trafficking, they can become major centres for relaxation and entertainment. Borders often become neutral zones, where law and order might be lax, and where entrepreneurs catering to the itinerant populations leads to such places becoming havens for activities such as illicit gambling and sex. Some border areas that have been known sites for gambling have recently established legitimate casinos with hotel and shopping complexes for the rich. Thus, there is an array of tourists, business people, and local and visiting officials who support licit and illicit trade and entertainment activities. Alongside these mobile populations are those working in the service industries, such as in shops and restaurants, and including sex work establishments, many of whom may be migrants. Other very mobile groups includes drivers, such as car and van drivers, and bus drivers, but probably the majority are the truck drivers who come from both sides of the border and who may terminate at the border's edge, or may cross some way into the country across the border.

Increasing trade, the construction of more buildings, and the creation of more infrastructure, adds to the ease of travellers and migrants reaching remote border points and staying in such destinations. The borders of Thailand and Cambodia studied in this report are part of this regional growth of trade and movement, but they are not thoroughfares for many people other than migrants. On the Cambodian side of the border the road conditions are poor and not too many Thai trucks venture far into the provinces. In Thailand, despite better roads and infrastructure many hazards await migrants seeking to gain work. This study determines who the main migrant groups are in the border areas, and how migration experiences and behaviour are linked to the HIV/AIDS epidemic.

Specific Objectives

The overall objective of the project is to conduct a situational analysis of border areas of Thailand on cross-border migration patterns and HIV/AIDS risk situations for migrant populations. The emphasis is on exploring correlation on migration processes, behaviour, and living conditions with vulnerability for HIV/AIDS. Specific objectives of the project are to assess the situations in Sangkhlaburi and Ranong at the Thai-Myanmar border on -

1. To provide a realistic estimate of the number of migrant population in the border locations of Thailand with its neighbouring countries;

2. To study behaviour and pattern of movement of the migrants from their place of origin to their destinations in Thailand;

3. To study the knowledge, attitude, belief and practice of the migrant population about HIV/AIDS and the resultant risk behaviours and risk situations. Identify the factors influencing such situations.

4. To investigate the transmission of HIV/AIDS at the border areas especially among the migrant population;

5. To examine the existing health care services (including HIV/AIDS) for the migrant population – availability, accessibility, acceptability and affordability. Identify "critical barriers" if any for the provision of services.

Study Area

Study areas are selected mainly on the basis of high volume of cross-border traffic but also information related to HIV/AIDS transmission in the area. In selecting sites the following issues were given special consideration:

1. The study sites are selected in immediate border areas where some workers may be daily commuters or longer term workers, and further inside the district or province where mainly workers are employed in various occupations like fishing, agriculture etc.

2. The population sample is taken from men and women over the age of 15. The focus is to explore attitudes, practices and behaviour of people of reproductive age or older.

3. The major themes in the research are the factors that influence the lives of migrants in their destination area, and lead to migrants being vulnerable to HIV infection. In order to undertake this exploration it is necessary to trace their lives back to their area of origin and the migration patterns, and means or processes of migration.

Based on the above considerations two sites on the Thai-Myanmar border were included in this study. Six more sites are being studied under the same criteria along borders of Thailand Mae Sai and Mae Sot (Myanmar border), Aranyprathet and Khlong Yai (Cambodia border), and Padam Besar and Sungai Kolok or Betong (Malaysia border). Two sites under this study are (see Map 1.1 and 1.2) -

1. Sangkhlaburi district of Kanchanaburi province opposite Phyathongsu town of Karen State popularly known as Three Pagoda Pass; and
2. Ranong Muang district of Ranong province opposite Kawthaung town of Tanintharyi division of Burma.

Expected Outcomes

The expected outcomes of this study is that we will know more about the lives of migrants, their migratory processes and the factors that make them vulnerable to health problems, particularly HIV/AIDS. Through an understanding of what they know about health matters and HIV/AIDS, and their attitudes and behaviour pertaining to sexual practices, and other behaviours that may be risky, we can determine strategies that lead to behaviour modification where migrants can apply protective behaviours in their lives. Through an understanding of

current programs, available health resources, and migrants access to health services, we can determine how existing infrastructure and services can be developed so that they are responsive to migrant's needs, and how they can be made sustainable.

Presentation of the Report

This study presents background, methodology, and findings from primary and secondary sources, plus analysis and recommendations for future programming of the two Myanmar sites. Chapter 1 presents the introduction, rationale, and general background. The methodology section in Chapter 1 provides an outline of population sampling, data collection, and analysis. Specific issues in data collection are discussed separately in the chapters on the two sites.

Chapter 2 presents a theoretical framework for migration and mobility followed by a discussion on population movements and HIV/AIDS looking at issues from around the world. A conceptual model is presented here as a flow chart that covers all relevant issues for this study.

Chapter 3 presents the situation and findings of the Sangkhlaburi-Phyathongsu or Three Pagoda Pass study, and Chapter 4 the Ranong-Kawthaung study. The presentation is very similar in both chapters with some variation due to different findings. Part 1 of these chapters includes the introduction followed by discussion on health services and the HIV/AIDS situation, and then the methodology. Part II is the demography of the study sample and findings on migration processes and behaviour. Part III is findings on HIV/AIDS knowledge, attitudes, and behaviour regarding sexual practices, sexual norms, and attitudes to people with HIV/AIDS, plus general aspects of risk behaviour. Summaries are provided of all sections, along with recommendations.

Chapter 5 summarises both chapters through comparing and contrasting findings on important themes in the respective studies. The sites are compared to develop an analysis of comparative themes in order to recommend appropriate strategies for prevention and care programs. Recommendations will take into account site-specific recommendations while providing broader strategies that will bring together different agencies and stakeholders to plan and implement appropriate interventions.

Methodology

The core of the research was a survey using a structured questionnaire. Objectives of the survey were to gain an understanding of the knowledge, attitudes, practices and beliefs of migrant workers in regard to HIV/AIDS and their situation as migrants. In addition to, and in preparation for, the quantitative survey qualitative approaches were utilised, using key informant interviews, in-depth interviews, observation, group discussions, and working closely with local health officials and others. The core survey was undertaken in January 1998 with follow-up visits.

ARCM staff collaborated with local individuals and organisations to prepare, plan, and implement data collection.

Map 1.1:

MAP OF THAILAND AND ITS NEIGHBOURING COUNTRIES SHOWING AND STUDY SITES

Map 1.2: Thailand - Burma/Myanmar Border Area

สถาบันวิทยบริการ จุฬาลงกรณ์มหาวิทยาลัย

Sampling Methods

1 Population estimates of migrant workers and specific occupational groups were undertaken through consultation with local officials from a range of individuals and agencies, including hospitals, health departments, employers, border officials and others.

2. Through gaining different reports of official and unofficial estimates a reliable final estimation was made from which population sampling could be calculated. The sample size is determined by using 30% of the population with 5% error, calculated from the following formula:

$$n = \frac{p \times (1 - p)}{\frac{(0.05)^2}{(1.96)^2} + \frac{p \times (1 - p)}{N}}$$

3. Purposive sampling was undertaken according to the occupations in which migrant workers are employed in the vicinity of the border area. Proportional sampling was used in accordance with the numbers employed in each occupation.

4. The principle of random sampling was followed to undertake individual interviews, with accidental sampling being used for some workers who were difficult to access.

Data Collection

Data collection methods from primary and secondary sources (both qualitative and quantitative) are outlined below:

1. Secondary data and statistics on population, migration patterns, and the HIV/AIDS situation.

2. Key informant interviews with government officials, NGO staff, health officials and other informants.

3. In-depth interviews, including sex workers who were used for case studies.

4. Informal group discussions with migrants from selected occupations.

5. KAPB survey of the study population by using a structured questionnaire. This is the main tool for the study and includes all relevant questions on population, migration pattern, and HIV/AIDS vulnerability.

Survey Instrument

After preliminary interviews with target group members and key informants plus observation a prepared questionnaire from previous research on the Thai-Myanmar border was modified to suit the new sites. Researchers, assistants, local officials, and outside consultants, all had input into the new design. The interviews were translated into Khmer by local people, health officials and other volunteers, who undertook two days of preparatory training. The

questionnaire was then tested in the field. Further site specific discussion on questionnaire and implementation are given in Methodological Issues in sections 3.4 and 4.4.

Research Variables

The variables used in analysis are presented in chart form as a conceptual framework in Chapter2. The three categories of variables used in the study are as follows:

1. Demographic data, which includes age, gender, education, marital status, occupation

2. Data on migration is explored in three phases i.e. pre-migration, migration, and post-migration; the latter includes living circumstances, length of stay, frequency of visiting home,

3. Awareness of STD/HIV/AIDS – misconceptions on HIV/AIDS, risk behaviour, attitudes to PWHAs, access to health care, and other relevant issues.

Data Analysis

Each site was analysed separately through bivariate analysis using demographic and migration behaviour variables against knowledge, attitude and behaviour in regard to HIV/AIDS, which includes risk behaviours and self-assessment of risk for contracting HIV. Significant and inferential correlation are interpreted and discussed.

Relevant migrant behaviour variables were not identical in both sites and the different variables and the different findings are discussed in the second report and then summarised in the final conclusion that compares sites and discusses the most relevant themes.

In each site five areas of knowledge were selected for systematic cross-tabulation. Three of the areas involved grouping questions together with the use of a scoring system. Each correct question received one point, a means was determined and then analysed through ANOVA (analysis of variables) F-test against the same sets of variables mentioned above. An alternative scoring system was used in the section on attitudes to people living with HIV/AIDS (PWHA) where +1 was used for correct answers, -1 for incorrect answers, and 0 for don't know/not sure answers. This was then analysed using ANOVA in the same way as above. In other sections on attitudes to high risk practices and self reported risk behaviours bivariate analysis was undertaken with a range of variables through simple cross-tabulations.

Multivariate analysis was undertaken as well, using the scoring systems noted above for knowledge and attitudes toward PWHA. Multivariate analysis, using linear regression, was undertaken for a range of predictive variables, selected from the variables noted above, then tested against knowledge of HIV/AIDS and attitudes toward PWHA. Attitudes toward high risk beliefs and practices as self-reported risk behaviours were tested by logistic regression analysis.

For each level of analysis the significant P value is $\leq .05$.

CHAPTER II

CONCEPTUAL FRAMEWORK OF CROSS-BORDER MIGRATION AND HIV/AIDS

Cross-border migration : definition and causes of migration

Cross-border migration is the mass movement of populations across the border from the country in which they belong to another country for a continuous living period where they are remunerated for work activities. The International Travel Regulations defines a period of 1 year as the length of stay in the new land which determines migrant status. Tourists who travel to a country are not migrants due to their short stay. Transients or sojourners who travel regularly from one country to another country are not migrants either according to such a definition.

However, migrants can also be classified with regards to their exposure to HIV/AIDS as follows (Decosas 1996):

1. Labour migrants: Migrant labourers cross borders to find employment, stay for a period of several months to several years at their destination, and return for long periods to their place of origin. Repeated or "circulatory" migration is the rule. Migration is often gender segregated, men follow different routes and have different destinations than woman.
2. Commuters: Commuting means frequent and regular travel between residence and area of work. It may be domestic or international. When the distance between the two sites becomes large enough, and when the frequency of movement slows to bi-weekly or monthly home visits, a situation analogous to labour migration arises.
3. Itinerant populations: Itinerant populations of traders and long distance truck drivers follow routes for several days or weeks at regular periodicity.

Migration can be classified by its causes. There are two causes, the first is natural or man made disasters. Another classification is by the decision of migrants, that is, voluntary migration and forced migration. In this study, we will focus only on man made disaster and voluntary migration.

Causes of migration are described by neo-classical and political economists. The former explains that people migrate due to economic motivation. They are thus economic migrants or labourers. Pull factors for migration are higher wages and better employment opportunities. People will move from economically less advanced countries to more advanced ones (Borjas 1989). Castillo-Freeman and Freeman (1992) indicate that the choice of destination depends on the different GNP in the country of origin and country of destination. Migration will correlate positively with GNP in destination country and negatively with GNP in country of origin. Other factors which affect migration are expenses for travel and types of employment (Cuthbert and Sterns 1981, Melendiz 1994 in Massey et al 1994).

Illegal international migration is caused by low wages, low agricultural productivity and high unemployment in the country of origin (Frisbie 1975). At the micro level, expected income in the destination country, along with expected contributions to

household income in the country of origin, determine the decision of an individual and his or her family to migrate (Taylor 1992).

While neo-classical economists describe the migration phenomenon from the perspective of the individual migrants and their families, political economists consider structural perspectives as pull factors. Labour markets in capitalist countries will develop a segmented labour market economy and pull labour force from economically less advanced countries to fill shortages. Piore (1979) and Taylor (1992) suggest that in economic migration the labour demand in the secondary sector in the destination country is a major pull factor. Castells (1989) and Sassen (1991) elaborate further that the economic internationalisation in the globalisation process determines the direction of international migration in such a way that migrants will move from their country of origin to "global cities". Population mobility is facilitated and enabled by modern transportation, flows of information and capitalist culture from the core countries to the peripherals. Sassen (1991) emphasises the emergence of illegal immigration as a result of economic internationalisation. Sassen observes that the off-shore production policies have created feminisation in the local labour market because some off-shore industries require female workers in light industries such as textile. food processing and electronic assembly as well as in the services sector. Female workers are generally treated as inferior to male workers.

Sociological theories consider migration as a system of which economic parameters are a part. Migration systems include economic, social, cultural, legal as well as political aspects. These systems also cover migration processes beginning with the decision to leave the country of origin, then the migrant's network in both countries, the network of migration facilitators and that of employers in destination countries (Castles 1993). Migration systems thus cover three stages of migration processes i.e., departure, migration and arrival. The variables in the five aspects and three stages of the system are summarised in the following table.

In the study of migration and HIV/AIDS, emphasis will be given to the stages of migration process and the arrival and stay in the place of destination because vulnerability takes place at both phases. As it is suggested from a public health perspective, the key link between human mobility and the epidemic profile of HIV is not in the origin of the migrant, but in the conditions of life during the voyage and at the site of destination (Decosas 1996). The following variables are listed for investigation in this study.

List of migration variables

Departure stage

- facilitation by relatives, friends or recruiters
- pre-departure orientation
- migration values
- travel from hometown to border town

Table 2.1 A Summary Migration Variables in the Various Stages and Systems of Migration

Stages \ Systems	Economic	Political (national & international)	Social	Cultural	Legal (national & international)
1. Departure (causes)	Relative economic deprivation in country of origin, wages and employment opportunities in destination country;	Inter-country special/historical relationship (e.g. colony), state policy on migration;	Migrant's social network (family, relatives, acquaintance and friends from same village/hometown)	Migration values, cultural influence from core-capitalist countries;	Emigration law in country of origin;
2. Migration process (process and facilitation)	Travel cost, fees charge for recruitment and travel arrangement;	National policy, bi-lateral/multi-lateral agreements, regional grouping;	Labour recruitment system (legal and illegal);	Relationship with brokers/recruiters, values on personal network;	Immigration law in destination country international covenant
3. Arrival (consequences)	Length of employment, remittances, economic activities in destination country, economic structure in destination country.	National policy, migrant's rights and responsibilities	Emergence of ethnic enclaves, social network in destination country, attempts to settle down.	Cultural adaptation, maintenance of ethnic identity	Labour law, nationality law in destination country, social welfare system

Source : Supang Chantavanich, ARCM, Bangkok

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

During travel stage

- recruitment charge, travel cost
- border crossing, stops on route
- legal immigration status

Arrival and residence in host country

- type of employment
- skills learned during overseas employment
- terms of employment
- working hours/days
- wage
- type of recreation
- length of stay
- type of living location
- live with family or separately
- language skills (of host country)
- knowledge about laws and regulations for migrants in host country
- remittances and sending valuable things back home saving
- participation in religions and traditional ceremonies
- marriage and giving birth in host country
- access to medical services
- intention to settle permanently
- plan to remigrate and return
- relationship with other migrants who stay in the same destination country
- relationship with local people

Concepts on the relation between international migration, health and HIV/AIDS

Most of the concepts outlined above are still at the development stage. Hendriks (1991) indicates that according to the International Travel Regulations and International Health Regulations, migrants are entitled to the rights to be treated when they are ill. With regard to AIDS, HIV screening of migrants is a violation of human rights. Migrants basic rights should also include ready access to knowledge on HIV/AIDS with consideration to their language and cultural background. Migrants should not be labelled as vulnerable but they should be described in such a way that the circumstances in which they live place many migrants in a vulnerable situation. Health Service providers should consider some of the circumstances that migrants live under, such as regular travelling as when they visit to their place of origin, living conditions (with family or separately), long absence from the social control of his or her home environment and socio-economic status (Decosas 1996). Decosas also indicates that vulnerability of migrants includes housing in single gender hostels and colonies; lack of access to medical care for sexually transmitted diseases; substance abuse related to loneliness and boredom; and a dysfunctional symbiosis between sex work and migrant labour (Decosas et al 1995, Abdool Karim et al 1992, Bronfman and Rubin-Kurtzman 1996). In some countries, labour camps of male workers are serviced by a few female prostitutes who may each have intercourse with 20-30 workers during a weekend following pay day (Kouame 1996). In Mexico, migrant labourers who stay at the border will be serviced by sex workers who also serve truck

drivers, military personnel, immigration officers and local people. This mixing pattern of sexual activity among male labourers increases the probability of HIV infection independent of the member of different sexual partners of each worker (Anderson 1996).

The vulnerability of particular groups of commuters and itinerant populations, such as traders and long distance truck drivers who follow routes for several days or weeks has also been observed. Truck drivers have become a major focus of HIV and STD prevention programmes aimed at migrant populations. Epidemiological data from seven countries in Africa indicates that HIV spreads along the main transport routes through truck drivers in "trucking towns" from coastal cities to the rural interior (Quinn 1994). However, other commuters like traders, salesman, railroad workers who have similar movement patterns are vulnerable also but are less visible. (Decosas 1996).

With regard to strategies for interventions. Hendriks (1991) suggests that knowledge can be provided at individual and group levels. Interpersonal media like hotline service, outreach programmes and training migrant volunteers to work with migrants are examples of individual approaches. At the group level, specific targets such as young males, homosexuals, drug addicts, refugees and illegal workers are a priority due to their lack of knowledge. Bilateral co-operation between countries can help to reach goals and prevent duplication of programmes.

Decosas (1996) emphasises the emotional and sexual needs of migrants at departure, during travel, and arrival in the host country. Intervention programmes should mobilise local media and local people along migration routes to contribute to programming e.g. intervention in partnership with transport workers and staff; collaboration with local migrant's organisation; and HIV education project, on ferries carrying migrant workers - conducted by volunteers who initiate group discussions and face to face interviews with migrants on board (Painter 1992, McKaig 1992, The Netherlands Institute of Health Promotion 1996 and Leaune 1996).

Programmes of HIV prevention among large male migrant work forces have to address the vulnerability of women in the host population too. Through health education and the creation of income opportunities it is possible to decrease the rate of STD and HIV transmission among women who are new sex partners of male migrants (Brewer et al. 1996). Bollini (1992) raises the issue of access to health care services for migrants. He suggests that language, cultural practices and communication channels are usually obstacles for migrants to obtain health care services. He also emphasises that a health policy for migrants must be developed and implemented within the context of national policies on immigration and overall national health policies which will determine the kinds of welfare and the legal status of migrants.

List of variables for migrant's vulnerability to HIV/AIDS

Pattern of living

- type of housing (single gender/mixed /colonies)
- substance abuse due to loneliness and boredom
- lack of social control for risk behaviours
- contact with family in country of origin

- illegal entry
- socialising/recreational activities

Risk behaviours

- sexual service during travel in order to earn income
- sexual intercourse with sex workers who have multiple partners
- sexual intercourse with women who have multiple partners
- sexual intercourse without condom
- anal sexual intercourse
- sexual intercourse with sex workers on pay day
- use of old syringes or shared needles
- drinking alcohol or substance abuse

Knowledge about AIDS

- Information on AIDS in country of origin
- language skills in destination country
- access to media in destination country
- knowledge about AIDS and its transmission
- knowledge on prevention and care

Access to health care services

- access to STD clinic
- access to health care services for illegal migrants
- language used in service provision
- costs of care
- access to health care services in general

Conceptual Model

The following conceptual model (Figure 2.1) represents most of the variables which have been reviewed above. Variables in this model can be classified into six categories, that is, demography, migration process, situation in destination country, HIV vulnerability, knowledge and attitudes to HIV/AIDS and finally analysis of the risk situations. In the initial stage of migration, education, age, gender, marital status and ethnicity are the demographic variables. Ethnicity can determine the level of education and language capacity. Education level, age, gender and ethnicity are related to the kinds of occupation a migrant worker might be engaged in. Marital status can determine the living conditions (live with whom) in the destination country. Age is related to the socialising pattern, type of housing, drugs and substance use, while gender is related to socialising patterns, and drugs and substance use as well.

Migration variables, which cover the factors occurring during the process of migration, include language skills used in the destination country (language limitation), migrant's status as a commuter. stops during migration to earn income, and availability of sex services during travel.

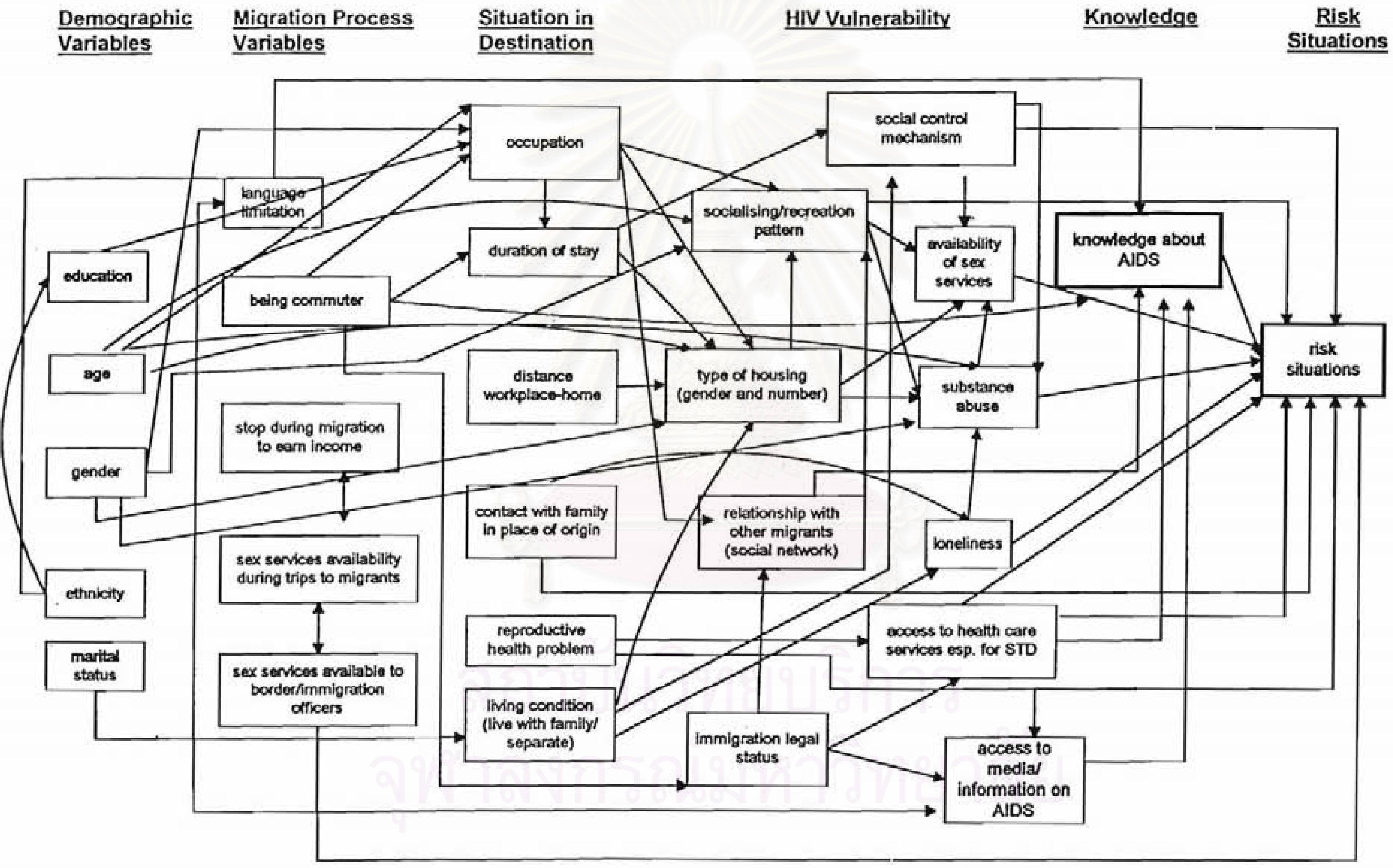


Figure : onceptual Model of Factors Affecting HIV/AIDS Knowledge

Being a commuter is related to the kinds of occupation, the duration of stay in the destination country and level of knowledge on HIV/AIDS. The three factors given above are important during travel or stops on the journey to the final destination. Availability of sex services to border/immigration officers is a related and pertinent factor in the existence of risk situations.

Once a migrant is in the destination country, factors related to HIV/AIDS include occupation, duration of stay, distance between workplace and home, contact with family in place of origin, reproductive health problems and living conditions (live with family or separately) at the destination. Occupation can determine the duration of stay which will be related to type of housing, the existing social norms and restrictions for migrants, who are far from home and lack social ties with family in place of origin, and their relationship with other migrants (social network). The distance between workplace and home is related to the type of housing too. Contact with family in place of origin is associated with loneliness and directly related to risk situations. Reproductive health problems are related to access to health care services, especially for STDs, and directly to risk situations. Living conditions (live with family or separately) is related to social norms or restrictions and loneliness.

With regard to HIV/AIDS vulnerability, the model includes the following variables: social norms and restrictions, socialising or recreation pattern, type of housing, relationship with other migrants, immigration (legal) status, availability of sex services, drugs and substance use, loneliness, access to media and information on HIV/AIDS. Social control mechanism is related to availability of sex services and substance use and directly linked with risk behaviours. Socialising pattern is related to availability of sex services. Type of housing is related to socialising pattern and to substance use. Relationship with other migrants is related to knowledge about HIV/AIDS, and immigration status is linked with relationship with other migrants, access to health care services and access to media and information on AIDS.

Loneliness is an important variable, which can influence drug and substance use, and lead to the use of sex services. In addition the three factors can affect directly the risk situations. Access to health care services especially for STD is related to knowledge about HIV/AIDS and to access to media/information on this topic. Meanwhile, access to media and information is related to knowledge.

Finally, knowledge and attitudes toward HIV/AIDS are the direct results of language limitations, migrant's status as a commuter, relationship with other migrants, access to health care services and access to media and information. They are also indirect results of other variables. Risk situations for HIV/AIDS are associated with social norms or restrictions, socialising patterns, contact with family in place of origin, access to health care services, sex services available to border/immigration officers, reproductive health problems, availability of sex services to migrants, drug and substance use, loneliness and level of knowledge and attitudes on HIV/AIDS.

Literature Review

Thailand has a long history of immigration from its neighbouring countries notably Laos, Myanmar, China and Cambodia. In recent years migration has been highlighted in three studies. Chaelemwong Y. (1996) estimated number of undocumented migrant labourers by province and showed their concentration along the border with Myanmar and in and around Bangkok. Archananitkil K. et al (1997) discussed the legal issues and state management system of the migrants. Chintayananda S. et al (1997) monitored the government effort to regularise migrant workers in the country. The authors pointed out that only 44.7% of the estimated 730,000 migrants registered. They then provided a series of recommendations for the improvement of registration process, enforcement of employment regulations including minimum wage and improve provision of health and welfare benefits. None of these reports however have provided detailed analysis of the border situations i.e. migration process and their living conditions particularly their vulnerability to HIV/AIDS.

Thai-Myanmar border has been in the focus for a decade of presence of large number of refugees and migrants streaming out of Myanmar. WVT in early 90s found out growing HIV/AIDS problem in some of the border provinces and began projects in Mae Sai and Ranong, and later in Mae Sot. Since then they have been constantly reporting high prevalence of HIV among various migrant population groups in their project reports and reviews e.g. pregnant women, sex workers and fishermen in Ranong, sex workers and pregnant women in Mae Sot, and sex workers and pregnant women in Mae Sai.

Paul S.R. (1996) showed that HIV prevalence along Thailand's border was higher than the national average especially areas bordering Myanmar, Cambodia and part of Laos. He later described in a follow-up article (1997) about the high prevalence of HIV among migrant labourers throughout Thailand including those in the border areas. But in a rapid assessment report on Thai-Myanmar border, Oppenheimer E. et al (1998) claimed that there was no data to suggest that the incidence of HIV/AIDS among migrants is higher than that among the host population. Nor were there data to suggest that they engage in more risk behaviours that the host community. The report however did not have sufficient data to substantiate its claims.

Asia Watch (1993) in a report highlighted the trafficking of thousands of Burmese women and girls into brothels in Thailand especially in Ranong, Bangkok and Kanchanaburi. Following this there were major police raids in Ranong, Bangkok and many other places during 1994-95 that resulted in closure of many sex establishments. Paul S. et al (1997) in a ARCM study report on reproductive health situation of migrant Burmese women in Ranong fishing community highlighted reproductive health problems including low knowledge and practice of family planning methods. They pointed out that many women were unaware of HIV/AIDS and condom use despite having multiple sex partners. Caoutte T. et al (1999) identified constraints and opportunities of reproductive health issues including HIV/AIDS at individual, relational and structural levels. According to them only 60% of the respondents could respond correctly to HIV/AIDS transmission.

Pattarakulwanich S. et al (June 1999) reports public health burden at the borders. From secondary data from 36 regional and general hospitals in 30 border provinces it forms a profile of aliens seeking health care in Thailand, noting that most are migrant workers and many are young. Treatment was mainly sought for communicable diseases that are preventable. but with little preventative health care migrants attending Thai hospitals create a serious burden on the health budget in Thailand.

Several papers from the proceedings of the Second Technical Consultation on Trans-national Population Movement and HIV/AIDS in Southeast Asia organised by ARCM in 1996 were useful for background material and in analysis of the findings. The country report on Myanmar by U Min Han and Rai Mra provided a comprehensive epidemiological picture of the AIDS situation up until 1995, the national response, migration issues and some of the pertinent issues in prevention. Naing and Karl Dorning provided useful analysis and strategies for the cross-border program.

Other documents related to the topic of HIV/AIDS and migrants or mobile populations are very recent. With border areas and mobile populations having emerged over recent years as a priority area for HIV/AIDS research and interventions the Cambodian-Thai border has become an important focus. One report by Thailand Seafarers Research Team co-ordinated by UNAIDS/UNICEF (1999) focuses on seafarers vulnerability in Ranong. Acknowledging rapid spread of HIV/AIDS it recommends intervention program including involvement of private sectors i.e. employers of fishermen. Entz A. (1999) in a epidemiological survey of fishermen at four locations in Thailand including Ranong found that 18% of the Burmese fishermen in Thailand are HIV-positive. This is the most seroprevalence survey ever conducted on fishermen in the country.

There are not many published literature on the situation of migrants in Sangkhlaburi and their HIV/AIDS vulnerability. Only Oppenheimer E. et al in their rapid assessment report covered this location in their rapid assessment report on Thai-Myanmar border.

CHAPTER III

CROSS-BORDER MIGRATION AND HIV VULNERABILITY AT SANGKHLABURI-PHYATHONGSU

3.1 BACKGROUND INFORMATION

Sangkhlaburi is a small district of Kanchanaburi province bordering Myanmar (Map 1.1 and 1.2). The province is located in the west of Thailand about 129 km from Bangkok. In terms of land area it is the third largest province in the country and draws very special attention because of its unique natural resources including its diverse forest and wildlife sanctuaries. About two-thirds of the province is covered by tropical forests and mountains. There are two large hydroelectric dams - Sri Nakharin and Khao Laem - built over the river Kwai that have created large fresh water lakes. The province is a popular tourist destination, and is very famous for eco-tourism, river and lake rafting, camping in the forests and parks, trekking and hiking. The province also has some important historical sites from the Japanese occupation during World War II notably *the bridge on the River Kawai.* There are three districts in the province, Sangkhlaburi, Saiyoke and Thong Pha Phum. Kanchanaburi has a 347 km long border with Myanmar bordering Tanintharyi division, and the Mon and Karen states. Because of the difficult terrain and forests, most of the border areas are difficult to access and only Sangkhlaburi has cross-border roads for transportation of people and goods between the two countries.

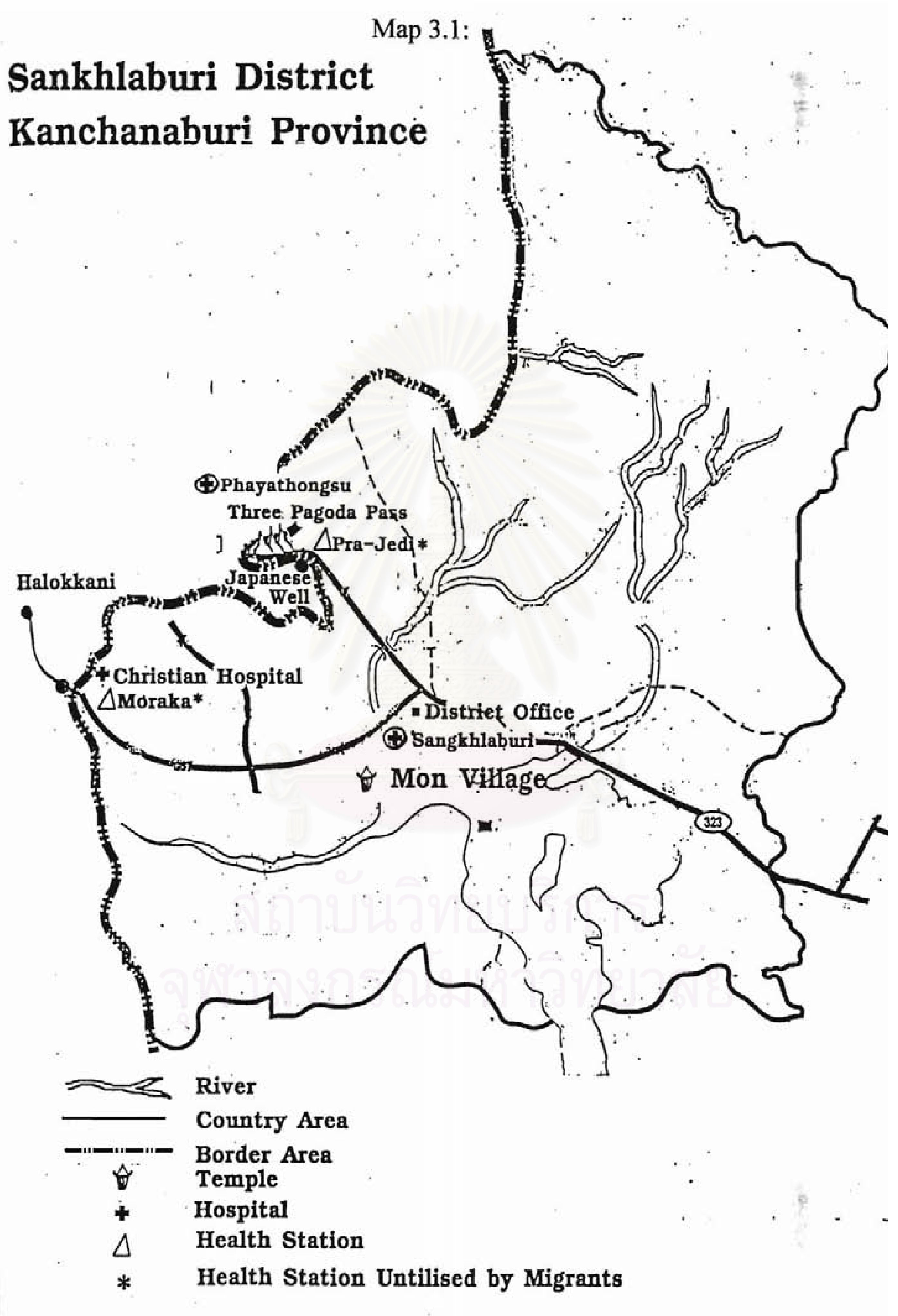
Geography of the Area

Sangkhlaburi district is about 150 km north-west of the provincial city (Map 3.1). About 70% of the district is covered by dense forests and mountains and only 515 square kilometre are of arable land. There are three sub-districts: Nonglu, Plangplae and Lao Vo. Nonglu is a large valley and is the main populated area which includes the district head quarters. *Chedi Sam Ong* or Three Pagoda Pass is the only official immigration check point in the province and is located in this sub-district. About half of Plangplae is covered by the Khao Laem dam and lake. Lai Vo is a remote reserved forest area and not accessible by road. The area is sparsely populated with only 11,606 inhabitants (Table 3.1), most of whom stay in Nonglu. The other two sub-districts have a fewer inhabitants.

Table 3.1: Thai Population in Sangkhlaburi District

Subdistricts	Households	Male	Female	Total	Remarks
Nonglu	1,800	3,727	3,459	7,186	Main populated area
Plangplae	362	1,090	1,369	2,459	1/2 Khao Laem dam and lake
Lai Vo	281	923	1,038	1,961	Remote reserve forest
Total	**2,443**	**5,740**	**5,866**	**11,606**	**Many inaccessible areas**

Source: District Health Committee, Sangkhlaburi



Map 3.1: Sankhlaburi District Kanchanaburi Province

Inside Myanmar, Moulmein district of Mon State borders the lower part of Sangkhlaburi district whereas the upper part is borders the southern parts of Karen State. Therefore, the area across the border is by and large inhabited by the Mon and Karen ethnic minority groups. There are three main border crossing points in the district (Map 3.1):

- Chedi Sam Ong-Phyathongsu or the Three Pagoda Pass: This is the official crossing point and trade route between the two countries. The crossing is renowned for its three ancient pagodas on the Myanmar side of the border.

- Chong Morakha-Halokkani: Well known for its access to several of the Mon refugee camps and resettlement areas inside Mon State of Myanmar. It is also the main unofficial deportation point for illegal migrants from Kanchanaburi and central Thailand.

- Japanese Well Village (*Bor Yepun*): Popularly known for a well dug by the Japanese during the second World War era. The place is known as an entry or re-entry point of large numbers of illegal migrants to Thailand.

In addition, there are several other forest trails which people use to cross this porous border between the two countries.

Local People and Culture

A great majority of the Sangkhlaburi population is Buddhist with some Christians and only a handful of Muslims. Most of the inhabitants belong to the Mon and Karen ethnic groups and have strong cultural links with their relatives and friends in the Mon and Karen states on the other side of the border. As a result, there are a lot of similarities in the tradition and culture. There have been uprisings and continual struggle for an independent Mon State ever since independence of Burma from the British colonial rule. Due to subsequent fightings in the area and heavy handed Burmese administration of the state, many ethnic Mon migrated and settled in Kanchanaburi, Ratchaburi, Samut Sakon and the surrounding provinces in Thailand. Migration has almost become a regular phenomenon in the area with many Karen hill-tribes in the district also. Other immigrants in the area are living with their relatives and friends. Sangkhlaburi has been known as a migrant resettlement area for the last several decades and by and large migrants out-number the local Thai population. According to the district office there are an estimated 20,000 or more migrants in the district compared to the local population of 11,606.

Trade and Economy

Agriculture is the main source of income in this remote district, and the main crops and plantations are rubber, dry mountain rice, cassava, banana and other fruit orchard. Poultry and cattle raising are other important sources of income. In addition, logging used to play an important role in the local economy until very recently when strict regulations were imposed.

Sangkhlaburi has its share of tourists in the province but is not very popular due its long distance from the provincial city. It is popular among river and lake rafters and eco-tourist groups. Many tourists go up to the Three Pagoda Pass border crossing. Table 3.2 provides a quick view of the Thai and Myanmar tourists crossing the border. There has been a steady

growth of Thai tourists from 1994 through 1997. In 1998, there was a sudden drop of Thai tourists visiting the area, probably because of the economic crisis in Thailand. Most of the Thai tourists usually go for a day trip with only a few spending a night in the Sangkhlaburi area. Similarly, Burmese tourists come to Chedi Sam Ong and return home on the same day.

Table 3.2: Tourists and Traders Crossing the Three Pagoda Pass, 1994-1998

	1994	1995	1996	1997	1998
Thai	52,412	56,068	77,240	103,699	83,248
Burmese	9,270	10,673	9,923	10,724	9,469
Total	**61,682**	**66,741**	**87,163**	**114,423**	**92,717**

Source: Sangkhlaburi immigration office

Cross-border trading with the people of Myanmar is also another important part of the local economy. Unlike Mae Sai-Tachilek or Mae Sot-Myawaddy, trading has never been so active here. This is probably because of the remoteness of the area and difficult road conditions on the Burmese side of the border. Cross-border logging from Myanmar to Thailand was very active in the past years but has ceased in recent years because of environmental concerns and the consequent pressure from lobbyists. The Burmese people continue to sell finished timber products such as furniture and handicrafts, bamboo, gems and jewellery, foreign liquors, cigarettes and souvenirs. Thais export household consumer goods and local food products, but also tractors, motorcycles and pick-up trucks. The official trade volume between the countries at the location is given in Table 3.3. It shows that Thailand continues to suffer huge trade deficits because of the following factors: (i) Myanmar has abundant natural resources to export to Thailand e.g. timber, rocks and gem stones. In future, they will export natural gas to Thailand following the completion of Yandan gas pipeline; and (ii) a poor buying capacity of the Burmese people because of the deteriorating economic situation in the country. The volume of cross-border trade is often an indication of the number of traders, businessmen and truckers visiting the area who very often form an important part of the clientele of the local entertainment venues, including the commercial sex industry.

Table 3.3: Trade Volume (in baht) at Sangkhlaburi-Three Pagoda Pass

Year	Import	Export	Trade Balance
1994	329,296,826*	22,410	-329,274,416
1995	33,833,821	2,301,575	-31,532,246
1996	74,748,394	4,613,990	-70,134,404
1997	78,899,584	12,881,138	-66,018,446
1998	136,910,969	19,033,485	-117,877,474

** huge amount of rock worth of 306,270,260 Baht was imported;*
Data Source: Custom office, Sangkhlaburi

Immigration and Border Control

Sangkhlaburi has a 170 km long border with Myanmar. The official immigration check point between the two countries is at Ban Chedi Sam Ong - Phayathongsu or popularly known as Three Pagoda Pass. It is located across from the township of Kya-Ain-Seik-Kyi, a district of

the Karen State. Thai people with a border pass can only go for a day trip to the adjacent areas in Phyathongsu, about six kilometres from the border. Those with a passport can stay overnight and travel beyond the area. Similar regulations apply for Myanmar nationals. Immigration authorities on both sides of the border collect a border-crossing fee of 25 baht per person for Thai and Myanmar nationals. Foreign nationals are required to pay $US18 each but no record is available if any foreigner has actually crossed the border or not in recent years. Motorcycle taxis from both sides of the border are permitted to transport passengers across the border, which forms the main mode of transportation for the Burmese residents in Phayathongsu as well as Thais in Chedi-Sam-Ong. Pick up truck taxis can be hired from the border to Phyathongsu for about 50 Baht.

Like in many parts, this site of the Thai-Myanmar border is also porous and cross-border movement of people and goods is not strictly controlled, permitting easy entry into Thailand and vice versa. Examples are two well-known crossing points, Halokkani and Japanese Well. The latter is named after a well dug by the Japanese soldiers during their short occupation of the area in the Second World War. Both of these locations are controlled by the New Mon National Party, an armed ethnic opposition faction of the Mon State. The party signed a peace agreement with the Government in 1995 after decades of failed struggle for an independent state. There are contrasting characterstics of these two crossing points. Halokkani has an open refugee camp inside Myanmar which houses an estimated 7,400 people, mostly Mon. This camp receives a large number of deported or returning illegal Burmese migrants from Kanchanaburi and central Thailand. There are several other Mon refugees camps in the area. There is one Karen refugee camp (Ton Yang) inside Thailand, just across from Halokkani. Thus the area is inhabited by refugees and migrants and is basically a mix of a large number of mobile populations. In comparison, Japanese Well is more renowned for serving as a gateway to illegal migration into Thailand. This village of 2,800 inhabitants heavily depends on its business with migrants, to whom they rent houses, sell food and commodities, and provide other services. Both Halokkani and Japanese Well have no official immigration check points but a large number of people move across the border in both places. There are many other small mountain trails criss-crossing the border, which are usually used by the illegal migrants entering or leaving Thailand. However, migrants in all of these unofficial locations have no significant relation with the migrants working in Sangkhlaburi, as the former are more interested in going to work in Bangkok and surrounding areas for higher wages.

Migrant and Mobile Population in the Area

As of April 30, 1997, a total of 13,276 migrant workers were registered in Kanchanaburi Province during a government initiated regularisation process, of which 13,114 were Burmese, 119 Laotians and 34 Cambodians. An overwhelming majority were employed in agriculture and some in domestic services and construction. The number of registered workers dropped to 9,581 in 1998. According to the provincial health committee, at present there are an estimated 100,000 undocumented migrant people in the province. This figure includes immigrants who received pink, orange and blue cards (see below). It is also an important fact that it is very difficult to come up with a close estimate of the migrants as they are very mobile and often work in remote areas which are beyond the reach of the immigration authorities. These figures, however, show gross inadequacy in the existing

government registration and regularisation process concerning undocumented migrant workers in the province and the country in general.

At present, Sangkhlaburi district has only 89 officially registered migrant workers. The district health office estimates the actual number at about 20,000. Some of these people are officially documented as "illegal migrants" by the local immigration office and provided with various immigration cards as follows (Table 3.4).

Table 3.4: Migrant Population in Sangkhlaburi

Migrants' categories	Number	Status
"Pink card", Mon arrived before 1976	3,332	Illegal migrants
"Orange card", Mon arrived after 1976	9,675	Illegal migrants
"Blue card", Karen hill-tribes	4,779	Eligible for Thai ID
Other migrants	not available	Illegal migrants

Source: Sangkhlaburi immigration office

In 1994, 3,332 Burmese migrants, mostly Mon who arrived in Thailand before 1976 received a 'pink card'. Another group of 9,675 people who arrived after 1976 received an 'orange card'. Both pink and orange card holders are officially categorised as "illegal migrants" but are widely accepted to live and work in the area. They are not, however, entitled to move to other parts of the country or take any permanent job with government agencies. A large number of samples were drawn from the orange card holders. A third group of 4,779 people, mostly hill-tribe Karen received a 'blue card' and they are waiting for Thai citizenship. As indicated earlier, many other migrants are joining their relatives and friends in the district and gradually taking up temporary jobs.

Moreover, as indicated above, there are many undocumented migrant workers who pass through this district to work in other parts of the province and the central regions of the country, such as Ratchaburi, Nakhon Phathom, Samut Sakon, Samut Prakan, Samut Songkram and Bangkok. They usually gather in Japanese Well or Halokkani for the organised departure by their "agents" and do not have much to do with the migrants in the Sangkhlaburi district.

In addition to the migrant workers, there are many other types of mobile population groups in the border areas of Sangkhlaburi such as military and border police, other government staff, pick-up and motorcycle drivers, sex workers, Burmese opposition student groups, and Mon and Karen political leaders and their supporters. Many of these groups often interact with the migrant workers depending on their work and personal interests.

Refugee Camps

There are four recognised refugee camps along the border with Sangkhlaburi (Table 3.5). Three of these camps - Bee Ree, Halokkani and Tavoy - are inhabited by the Mon. and are located inside Myanmar territory. These camps are managed by the Mon National Relief Committee. Ton Yang is the only camp for Karen in the area, which is located inside Thailand and controlled by Thai authorities. In fact there are a large number of resettlement camps or villages in the area controlled by the New Mon Nationalist Party and some by the

Karen. While some of these are new camps, many of them are old villages that were once deserted during the war and are now repopulated by returning villagers. Halokkani has a special link with migrant workers because many of them who got arrested in central Thailand are unofficially deported by the Thai authorities to this camp through the Kanchanaburi Immigration Detention Centre (IDC) (see Deportation). Other Mon refugee camps are also open and at least some of their residents work outside in the Sangkhlaburi district or elsewhere in Thailand.

Table 3.5: Refugee Camp Population*

Camp	Ethnicity	# of Families	Population	Comment
Bee Ree	Mon	488	2,776	Open camp, few migrants
Tavoy	Mon	433	2,410	Open camp, few migrant
Halokkani	Mon	1,343	7,479	Open camp, many migrants
Ton Yang	Karen	--	1,750	Closed camp, no migrant

** There are more camps and resettlement areas in close proximity of the border;*
Data source: Sangkhlaburi district health office and Mon National Relief Committee

Deportation of Illegal Migrants in Sangkhlaburi

Illegal migrants from Myanmar who get arrested in Thailand are sent to the IDC in Bangkok. They are then deported through one of the three cross-border points with Myanmar namely, Sangkhlaburi, Mae Sot (Tak province) and Ranong. Of the three, Sangkhlaburi receives a great majority of the deportees possibly because of its close proximity to central Thailand and Bangkok, and good local cross-border relations. The deportees are transferred from the Bangkok IDC to the Kanchanaburi IDC where they have to wait for a few days to weeks before being sent to one of the three deportation points in the district, i.e. Halokkani, Three Pagoda Pass and Japanese Well. The duration of the deportation process depends on the number of detainees at one time. Usually, a deportation trip is organised once the number of detainees reaches about 200 to 300 at the Kanchanaburi IDC. The larger the number of detainees, the shorter is the time they have to wait in Kanchanaburi.

In-depth interviews with several deported migrants reveal that police abuses occur in both Bangkok and Kanchanaburi IDCs which range from cheating, taking personal belongings, physical assaults and sexual exploitation. Both immigration officials and Thai chiefs of inmates are said to be involved in these acts. Amphetamine use occurs among some prison inmates but there is no reported incidence of intravenous drug use in the IDCs. According to the deportees and local informants, medical care in the IDCs is inadequate, and there have been a few reported case of fatal incident among prisoners.

Some reports indicate that the migrant female inmates are particularly vulnerable to sexual abuses in both Bangkok and Kanchanaburi IDCs (Asia Watch 1993). This has been confirmed by former inmates of the IDCs and other informants in the area. The CMH has also reported a few rape victims among deportees from both IDCs who received medical and psychological care in their hospital.

As mentioned above the deportees are sent to one of the three designated areas, Halokkani, Phayathongsu and Japanese Well based on the following ill-defined criteria:

⇒ Halokkani receives the majority of the illegal Burmese deportees. These people are usually arrested in the *Muang* district of Kanchanaburi and other provinces in central Thailand. They are detained in the Kanchanaburi IDC before deportation. Halokkani is an open camp and there is no official hand over of deportees to the authorities in Myanmar. Migrants usually find their own way home from Halokkani. Some of them actually come back to work in Thailand, usually through Japanese Well.

⇒ Phayathongsu, or the Three Pagoda Pass is usually used for illegal migrants who volunteer to go back to Myanmar and report to the immigration offices in Thailand. These people do not have to go through the Kanchanaburi IDC. Migrants who are arrested in Kanchanaburi Province (except Muang district) are also directly deported to Phayathongsu. Thai authorities officially hand over the deportees to the Burmese authorities and the migrants are required to pay the Myanmar immigration fees.

⇒ Japanese Well village is used for the repatriation of similar types of deportees to those of Phayathongsu but more so for illegal migrants. This site is used less frequently than Phayathongsu and there is no official hand over to the Burmese authorities. This area is popularly known as an entry point to Thailand rather than a deportation area.

Usually two truck-loads of 200-300 detainees are deported through Sangkhlaburi - mostly to the Halokkani camp - once or twice a week. Some available data from the Sangkhlaburi immigration office reads as follows:

Migrants arrested/deported in Sangkhlaburi	January - December 1998:	663
	January - March 1999:	223
Migrants arrested/deported in other places	August - December 1997:	4,700
	January - August 1998:	8,045
Voluntary repatriation from all places	January - December 1998	16,006

In Halokkani, deported migrants seek shelter in the camp for a day or two. They receive a three days rice ration provided by the NGOs. Those who have enough money take a trip by passenger pick-up to Ye Town in the Mon state and those without money walk back home. A passenger pick-up takes about six to eight hours compared to two days of gruelling walk through rough terrain. There are several check-points on this road controlled by Karen, Mon and student groups. Some of them provide food and first aid care to returnees if necessary. Some returnees also seek help from local Mon and Karen villagers when they run out of food or fall ill. Malaria is highly endemic in the area and is a common illness among the migrants. In addition to exhaustion, people also complain of tingling and numb sensations of their lower and upper extremities, often diagnosed as Beri Beri by the local medics.

No definitive information is available to indicate sexual exploitation and casual sexual relations among illegal migrants. Usually returning migrant women wait for friends or known villagers to form groups before going home. This is intended to protect them from possible dangers on the way. Some women also pretend to be wife of a particular man (often hired) who then protect her from others. Nevertheless, the migrant population - both men and

women - still go through the "risk situations" for the mobile people and can get involved in unsafe sex or drug use in some circumstances.

Migrants released in Phayathongsu are usually handed over to immigration officials in Myanmar by Thai immigration officials. A detainee is then asked by the Burmese immigration to pay 450 to 500 Baht to allow him/her to return home. As a result, some returnees take motorcycle taxis in Chedi-Sam-Ong in order to avoid Burmese immigration and pass through one of the several back roads to Phayathongsu. Such a trip costs about 200 Baht per person, which is more popular than the official immigration channel.

3.2 HEALTH SITUATION AND HEALTH SERVICES

Sangkhlaburi is a small remote district and the health situation here is similar to many other rural areas of Thailand with special characteristic of a border district where some communicable diseases are more prevalent. Malaria is the single most important factor in morbidity and mortality in the area, and is much more common in the mountainous areas of adjacent Myanmar. Other common illnesses are diarrhoea and respiratory infections. Tuberculosis is still a problem among certain population groups. Only a few cases of STDs and AIDS are reported from the hospital services.

The district has relatively well developed public (government) and private health sector services. The public health system consists of a district hospital and a network of six Tambon (sub-district) health stations. Private health sector services consist of the CMH, NGOs providing health care to the refugees and the Mon health care system. The resettlement areas inside Myanmar (sometimes linked with the NGOs) provide a range of private clinics, drug stores and traditional healers. Migrants working in Sangkhlaburi receive health care in all public health facilities and the missionary hospital. NGOs are not involved in the health care activities inside Thailand. Refugees and migrants on the Myanmar side of the border are supported by the NGOs and the Mon relief committee. However, patients from these NGOs supported services are referred to both hospitals in Sangkhlaburi.

Sangkhlaburi District Hospital

Because migrants constitute a major portion of the local population, Sangkhlaburi hospital provides both outpatient and inpatient services to them. Tables 3.6-3.8 provide a glimpse of the patient statistics of the hospital. Non-Thai patients include migrant workers, hill-tribe settlers and refugees. The available breakdown of hospital delivery records, however, shows that there are more non-Thai patients than Thai patients (Table 3.7-3.8). The in-patient service comprises 30 beds and provides care for all common illnesses plus minor surgery. Patients with major surgical problems are referred to Kanchanaburi. The hospital also has a good laboratory and blood screening facility for transfusion purposes. Outpatient services include treatment for common illnesses, follow-up of chronic or long-term illnesses such as tuberculosis, maternal care and children immunisation. In addition to the district hospital, government's Tambon clinics provide primary care to Thai and non-Thai patients. Patients are required to pay for the services and only the poor who can not afford the cost may seek social service supports. Patients who are referred by NGOs from the refugee camps are covered through the particular NGO's. No data is available to show what proportion of non-

Thais did not pay for the services. Overall, public health services are the main provider for migrants in the area.

Table 3.6: Non-Thai Patients in Sangkhlaburi Hospital

Patients	1996	1997	1998
Outpatients	-	1,357	1,171
Inpatients	-	346	587

Source: Sangkhlaburi hospital

Table 3.7 shows that there are more non-Thai patients than Thai patients who had deliveries in the Sangkhlaburi hospital. There are three main reasons for this. First, as mentioned earlier, migrants outnumber the Thai population in the district. Second, some Burmese patients with delivery complications are referred from the refugee camps inside Myanmar. Third, and perhaps the most important reason is the fact that the child-spacing methods are not widely practised by the migrants which is similar to other Thai-Myanmar border locations.

Table 3.7: Delivery in Sangkhlaburi Hospital

	1996	1997	1998
Thai	82	95	90
Non-Thai	159	179	176

Source: Sangkhlaburi hospital

In addition to the hospital, a good number of migrant patients visit Tambon or sub-district health stations which provide maternal and child health services (e.g. immunisation, antenatal check up etc.) and treatment for minor illnesses. Once again, the number of migrant patients visiting one of the health stations such as in Chedi Sam Ong outnumber the local Thai patients (see Table 3.8). Overall, the migrant population in Sangkhlaburi has adopted the local health care system and has developed almost similar health care practices as the local Thai people. However, they still have significant differences in sanitation and environmental practices.

Table 3.8: Number of Patients in Chedi Sam Ong Health Station

	1996	1997	1998
Thai	273	687	1,123
Non-Thai	708	720	1,765
Total	981	1,407	2,888

Source: Sangkhlaburi health office

Christian Missionary Hospital (CMH)

The Christian Missionary Hospital is the most important privately run health care facility in the district. It is located at Morakha (Map 3.2) and close to the Ton Yang and Halokkani refugee camps. It has outpatient department and ten bed inpatient services. A majority of the patients seeking treatment here are refugees and migrants, many of whom have been deported

from central Thailand. Local Thai people and the migrant settlers are also users of the hospital. The total number of hospital visits and hospital deliveries remained static over the last five years (Table 3.9). Overall, this hospital is more popular among migrants and refugees, especially those who do not speak Thai well, because of the availability of Mon and Karen speaking staff. The Christian Missionary Hospital also is not too rigid about payments because it relies on outside funding rather than a self-generated income. Patients who are referred to the hospital from the refugee camps are usually reimbursed by the NGOs.

Table 3.9: Non-Thai Patients in Missionary Hospital

No. of patients	1994	1995	1996	1997	1998
Hospital visits	12,487	10,735	10,736	11,944	11,403
Deliveries	167	145	167	193	147

Source: Christian Missionary Hospital

There is no facility in the hospital to store blood and thus it only relies on emergency blood donations. Antenatal care was introduced in 1998, and HIV, Malaria, and Hepatitis are investigated among pregnant women. Testing for Syphilis is not included in the antenatal care. The hospital has no outreach activities for health education or other preventive services. If included in the existing services, this hospital could play a crucial role in the preventive health care including HIV/AIDS prevention and care.

Rehabilitation Centre: In addition to the above services, the Christian Missionary Hospital runs a rehabilitation centre that provides food, shelter, treatment and care for the physically and mentally disabled migrants including those who are arrested in the area, or who are in the process of deportation. In 1998, eight HIV/AIDS patients - two females and six males - were admitted to the rehabilitation centre. Patients who recover either return home by themselves or are sometimes repatriated to Myanmar through a nurse stationed at the Phayathongsu hospital.

Patients interviewed at this centre have given a very dark picture of what migrants have to go through in the Thai IDCs in Bangkok and Kanchanaburi. According to them, the living conditions in the IDCs are very harsh and intolerable. The detained migrants go through a range of abuses and punishments by the immigration officials and other prisoners which range from physical torture, confiscating possessions, sexual exploitation and abuse. The female detainees are particularly vulnerable to the latter. Most of the mentally ill patients at the centre come from the Bangkok and Kanchanaburi IDCs. It is reported that some cases of mental disorders have occurred during a brief detention period. Even several months after their release, patients could not remember what had happened to them during the detention period. In general, male migrants appear to be more susceptible to these mental illness than female migrants.

American Refugee Committee (ARC)

ARC, an American NGO, provides assistance to the Karen refugees in the Ton Yang camp in Thailand, which is situated close to the Halokkani Camp. A population of 1,750 refugees is strictly controlled by Thai authorities and outsiders are prohibited to enter the camp. Only a few refugees are occasionally allowed to travel to Myanmar. The ARC supported services

include maternal and child health, family planning, health education and environmental sanitation. In January 1999, a condom campaign has been launched for the prevention of STDs and HIV/AIDS and the promotion of birth spacing.

Medicins Sans Frontieres (MSF)

MSF, a French NGO, provides assistance to the Mon refugees in the Halokkani camp. MSF is also responsible for the training and supervision of 98 medics who provide health services in the ten out-post clinics at camps and settlements inside Myanmar controlled by the New Mon National Party. Patients requiring blood transfusion are referred to three of the larger camps. There is no blood storing facility, thus relatives and health staff are usually called upon to donate blood. Blood donors are tested for Malaria, Hepatitis and HIV. Approximately 20 patients need blood transfusions each month of which the majority are children. Halokkani camp has four laboratory technicians and 24 nurses. Antenatal care is also provided to pregnant women but tests for Syphilis and HIV are not available at the moment. Between February 1998 and March 1999, the health staff reported to have identified nearly 20 patients, all of them migrants, who have suspected symptoms of AIDS. An HIV test was not performed in the camp and the patients were referred to the Missionary Hospital. During the same period, 30 men and women have come for the treatment of STD-like symptoms.

Halokkani camp is quite different from other refugee camps, as it is largely open to the outside. It serves as a gateway to both incoming migrants from Ye town of Myanmar as well as repatriated illegal migrants from Thailand. Marriages between camp residents and migrants are common. There is a growing awareness among senior MSF staff to initiate an HIV programme in the camp. However, interviewed Mon medics only showed limited awareness of HIV/AIDS. They have not received any specific training on HIV and STDs so far. HIV/AIDS intervention programmes are yet to begin in the ten camps. It is also learned that 70 % of refugees and Mon staying in the area controlled by the New Mon National Party can read Mon script which indicated that IEC material in Mon language will be useful for awareness campaign in the area.

One of the ten health clinics run by the New Mon National party is in Japanese Well. The centre's health staff comprises seven people. Malaria, diarrhoea and upper respiratory tract infection rank as the leading causes of illness in both in-patient and out-patient services. Other common illnesses are Beri Beri, Gastritis and Worm Colic. During the period of October 1, 1998 to March 18, 1999, 422 patients received treatment in the clinic. Patients requiring blood transfusion were referred to the CMH. The clinic uses disposable needles and syringes, and discards are either buried or burned. Surgical instruments used for dressing are sterilised with Savlon and autoclave. Condoms are supplied by MSF but not distributed widely for any purpose. The health staff has not received any HIV counselling training. STDs and HIV/AIDS are not emphasised in their initial six to nine months training. The ratio of female to male medics is 60:40. Men are usually assigned to out-post clinics located in rough terrain inside Myanmar while women are accommodated at stations closer to the Thai border.

Drug Stores

There are two drug stores in the Sangkhlaburi district. One of them reportedly provides treatment for STDs to sex workers which include oral and injectable antibiotics and diuretics.

The injection of antibiotics is also prescribed for the prevention of STDs. This causes the misperception among sex workers that they are immune to STDs and that there is hence no need for other prevention such as condom use. Sex workers interviewed in Sangklaburi confirmed that they had received antibiotic injections provided by the particular shop. The owner of the other drug store is currently undergoing training on STDs management with the Ministry of Public Health and reportedly does not like to give antibiotic injections.

Phayathongsu Hospital (in Myanmar)

This 60 bed hospital is the largest in the nearby area of Myanmar. The actual bed occupancy rate, however, appears to be lower than its present capacity. The hospital is staffed by three nurses and one doctor. There is also a laboratory technician and a pharmacist in the hospital. There is no special STD clinic and HIV testing is not available. VDRL and HIV testing are not routinely undertaken for pregnant women. There is no facility for blood storage making the hospital depend on emergency blood donations. Disposable needles and syringes are used for injections. Only minor surgeries are performed in the hospital. Delivery services are also available but only a few women come to the hospital because traditionally they prefer to have home deliveries. The Maternity and Child Welfare Association (MCWA) of Myanmar, a semi-NGOs, also provides antenatal care and delivery services in the Phayathongsu area. In addition, there are two drug stores and two private clinics operating in the town, which appear to be the main service providers for local residences.

3.3 HIV/AIDS SITUATION IN SANGKHLABURI

It is very difficult to provide a good analysis of the HIV/AIDS situation in the district, especially among the migrant population, as there is no systematic surveillance or data collection is in place. Population dynamics are great in the area and HIV testing among the migrant population is strongly discouraged by many groups, including human rights activists. However, data gathered in a study conducted by the Asian Research Centre for Migration (Oppenheimer, E. et al, 1996) indicated that 17 HIV-positive migrants from central Thailand returned to the border. Sangkhlaburi hospital recorded 14 HIV-positive patients in 1998 out of 64 tests conducted at the hospital. This is a very significant increase compared to only four positive cases out of 303 tests in 1996 and three cases out of 39 in 1997 (see Table 3.10).

Table 3.10: HIV Testing of the Migrants in Sangkhlaburi Hospital

	1996	1997	1998
Number of HIV tests	303	39	64
HIV positive	4	3	14

Source: Sangkhlaburi hospital

Sangkhlaburi hospital has recorded 13 VDRL positive patients out of 855 tests conducted in 1998 (Table 3.11), a significant increase from very low numbers in the previous years. The CMH reported 24 HIV-positive patients in 1998 (Table 3.12) which indicates a increase of HIV-positive cases compared to the previous years. Interestingly, most of these HIV-positive patients are coming from the Sangkhlaburi area which is considered as a low risk population because of their living situations with their families and very small commercial sex industry.

There are also a number of cases from the IDC as well as patients from the refugee camps. It should be mentioned here again that HIV testing is not routinely conducted among patients in the hospital except for blood donors and pregnant women.

Table 3.11: VDRL Test of Migrants in Sangkhlaburi Hospital

	1996	1997	1998
Number of Tests	835	110	855
VDRL positive	3	1	13

Source: Sangkhlaburi hospital

The director of the hospital suspected that most of the transmissions occur through unsafe sex, tattooing and intravenous drug use. As mentioned earlier, the hospital does not have a special STD clinic nor any outreach prevention activities for HIV/STDs.

Table 3.12: HIV-Positive Patients in Missionary Hospital

	1994	1995	1996	1997	1998
Thai	-	**3**	**4**	**2**	**9**
Non-Thai	**12**	**23**	**19**	**11**	**24**
Sangkhlaburi	4	10	8	4	13
Refugee camps	2	7	5	3	2
IDC cases	6	6	6	4	9

Source: Christian Missionary Hospital

Medics of the New Mon National Party and the Rohinga Rescue Association estimate the presence of about 20 HIV-positive cases in 1998 in the area. However, Halokkani camp medics alone reported to have identified about 20 people - most of them returnees migrant from central Thailand - with suspected symptoms of AIDS. None of them, however, were tested for HIV which is not available in the camp and in fact testing is strongly discouraged without proper counselling services. In Japanese Well, two HIV-positive returnees were reportedly identified. The village headman responded by forcing them out of the village and

Table 3.13

HIV Sentinel Surveillance Results in Selected Thai-Myanmar Border Provinces

Mean HIV Positive Among Pregnant Women, 1991-98

Locations	Jun 91	Dec 91	Jun 92	Dec 92	Jun 93	Dec 93	Jun 94	Dec 94	Jun 95*	Jun 96	Jun 97	Jun 98
Thailand	0.81	0.63	1.00	1.00	1.39	1.50	1.78	1.61	2.29	1.81	1.68	1.85
Kanchanaburi	0.78	0.49	0.85	2.58	1.39	1.88	4.36	2.25	3.02	2.95	2.59	1.05
Ranong	1.00	1.00	3.55	2.94	7.56	4.21	3.77	3.57	2.78	2.34	2.17	3.17

Mean HIV Positive Among Direct Sex Workers, 1991-98

Locations	Jun-91	Dec-91	Jun-92	Dec-92	Jun-93	Dec-93	Jun-94	Dec-94	Jun-95*	Jun-96	Jun-97	Jun-98
Thailand	15.24	21.83	22.97	23.86	28.67	29.52	27.02	33.15	17.79	27.78	26.14	21.82
Kanchanaburi	32.65	23.63	29.00	41.00	36.50	46.60	37.42	42.76	49.33	n.a.	33.61	25.87
Ranong	15.83	24.31	37.38	28.00	52.20	35.93	38.00	n.a.	14.67	n.a.	n.a.	n.a.

* Mixed Direct and Indirect Sex Workers; n.a. = data not available;

HIV Data source: Division of Epidemiology, Ministry of Public Health, Thailand

followed up by expelling a number of sex workers. The villagers now "get married with people from in and around their village" out of fear of contracting the disease from outsiders. Other anecdotal information from various local sources indicates that HIV/AIDS is gradually becoming a problem in the area.

Finally, HIV sentinel surveillance data of the Kanchanaburi province, for which usually no sample is taken from the migrant population, indicates that HIV-positive rate among direct sex workers remains higher than the national average (Table 3.13). The infection rate is also higher among pregnant women except for 1998, when it has dropped to 1.05%, slightly lower than the national average.

3.4 METHODOLOGICAL ISSUES

A team of five researchers - four Thai and a Burmese doctor - did a week long field work and exploration. Most of the researchers are well aware of the local situation. The Burmese doctor works in a project covering several sites on the Thai-Myanmar border and is a native Burmese speaker.

Study Period

The study preparations, including the development of the questionnaire, were conducted in November and December 1998. A three days field trip was made in December 1998 to collect background information on target areas and population, and to identify local teams, partners and interpreters. A two day workshop was organised in Sangkhlaburi for the orientation and training of the local team and interpreters. It also served to review and test the structured and other research questionnaires, and to identify and contact key informants. Data collection was conducted on 13 - 20 March 1999 followed by data entry and analysis in April and July 1999.

Scope of the Study

All respondents were chosen from the Sangkhlaburi area including Chedi-Sam-Ong inside Thailand. These people are employed inside the Sangkhlaburi district. Study samples were taken on the basis of proportional representation from each of the occupational groups provided by the local authorities. The sample did not include transportation workers (truck and pick-up), military and border police, other government officials and staff who form an important part of the local activities and the HIV/AIDS risk situations. Although the researchers had access to Phyathongsu, Halokkani and Japanese Well inside Myanmar, it was not possible to conduct structured interviews there. However, in-depth interviews were taken at all three places to understand the significance of those places and the overall migrant situation in the area. These three places inside Myanmar have large numbers of prospective or returning migrants from central Thailand. It is expected that there are differences between migrants in Sangkhlaburi and those going to work in central Thailand. Thai population - both local and mobile - are not included in the study.

Constraints and Limitations

The team used multilingual interpreters (Burmese, Mon, Karen and Thai) to communicate with the respondents, some of whom were not proficient in all languages. As a result, the interview process was rather slow but not necessarily compromising the quality of study. It was not possible to have full access to all of the 20-25 indirect sex workers in Sangkhlaburi and the surrounding areas because they are very discreet and highly mobile. Only five of them were briefly interviewed and the interviewers could not make use of a full length structured questionnaire.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

STUDY FINDINGS ON MIGRATION SITUATION

The following sections provide a detailed analysis based on the responses to the KAP questionnaires of a 327 sample population. These analyses vary from simple frequency to cross-tabulation and correlation among variables. Some relevant qualitative information and analysis has been used in support of the quantitative data to elaborate the depth understanding of the issues. The main body of these findings are organised in the following two sections - demography of the study sample and migratory experience.

3.5 DEMOGRAPHY OF STUDY SAMPLE

Of the total 327 respondents, 200 (61.2%) are male and 127 (38.8%) are female (Table 3.14). This gender breakdown is consistent with national data that show that about 30% of undocumented migrant labourers in Thailand are female (Paul S, 1997). The mean age of the respondents is 29.5 years and more than half of them (male 56.7% and female 63.8%) are below 30 years of age. No respondent was selected below 15 years of age, which effectively left out the minors and children in the quantitative analysis although they constitute a significant segment of the migrant and mobile population in the area. This is supported by the fact that about 81% of the respondents live with their families (Table 3.25) and many people had children born in Thailand.

Table 3.14: Age and Gender of the Respondents

Age Groups	Male		Female		Total	
(years)	Number	%	Number	%	Number	%
Below 18*	14	7.0	10	7.9	24	7.3
18 - 20	23	11.5	14	11.0	37	11.3
21 - 30	77	38.5	57	44.9	134	41.0
31 - 40	61	30.5	33	26.0	94	28.7
Over 40	25	12.5	13	10.2	38	11.6
Total	**200**	**61.2**	**127**	**38.8**	**327**	**100.0**

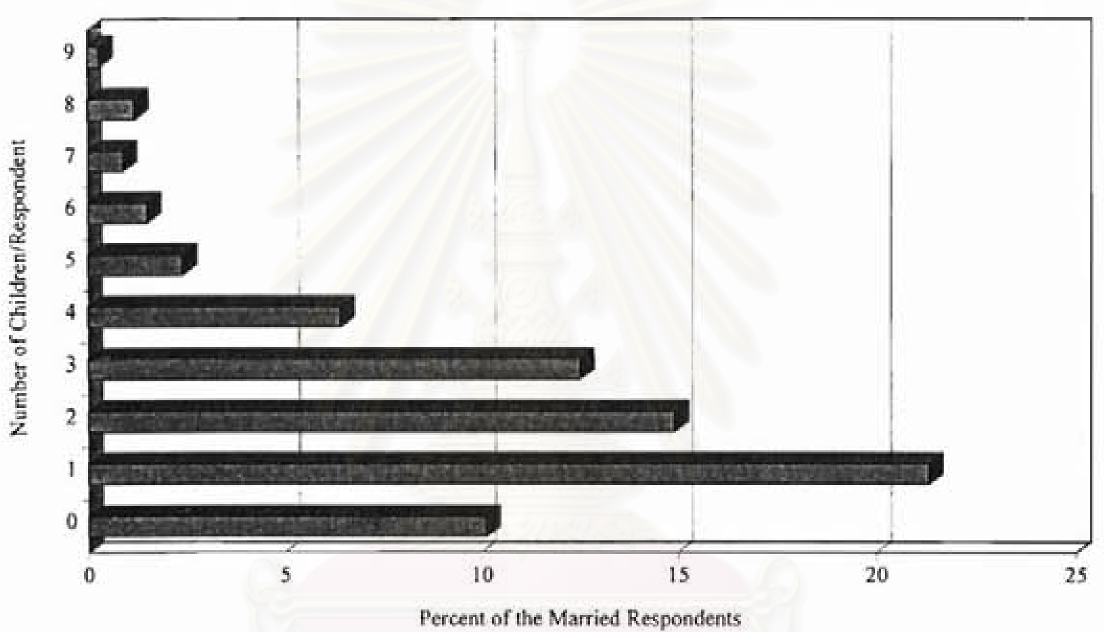
* *This breakdown is used to show the internationally recognised age for child labour;*

Migrant Children

There are children of all ages in the migrant communities in Sangkhlaburi. Figure 3.1 shows that 42.3% of the married people had children born in Thailand. Almost all of the children live with their nuclear or extended family. It is hard to find an unaccompanied child in the area. The migrant children are allowed to go to Thai schools and study in Thai. There is no readily available data to verify their enrolment rate. A special school for migrants does not exist. However, many families continue to have private education in their native languages - Mon, Karen or Burmese - at home or with private tutors. Most of the children help their parents and families with domestic work but there is no clear evidence of organised child labour in the area. In fact, 7.3% of the sample population is below 18 years of age and could by international standards be categorised as child labourers although Thai law allows children over 15 years of age to work in certain occupations.

Trafficking of women and children from the border to the inner districts were reportedly common in the past. Many of these young girls were used in the commercial sex industry in Thailand and occasionally, in other countries of the region (Asia Watch 1993). In recent years, trafficking for sexual exploitation has decreased significantly which is attributed to two main reasons. First, since 1994, the Thai government has been placing special emphasis to curb child prostitution in the country. There have been numerous raids and arrests, and eventual closure of many brothels and other sex service venues. Second, following a revision of the Thai prostitution law in 1995, the government has vigorously implemented an old law that prohibits direct sex services in brothels and other venues. Even then some migrant girls are coerced into sex businesses in Sangkhlaburi (see section 3.10, sex workers).

Figure 3.1: Number of Children Born in Thailand



Ethnicity and Religion

Most of the respondents belong to one of the two dominant ethnic groups in the area i.e. Mon and Karen (Table 3.15) as the Sangkhlaburi district is situated opposite of their home states. The district also is a host to a large local population of the same ethnic groups, many of whom either lived in the trans-border area or have actually migrated to Thailand some time ago. These two ethnic groups and some other ethnic minorities are in conflict with the government in Myanmar dominated by the majority ethnic Burmese population. Over the years the Mon and Karen population in Myanmar have been depleted as they continued to migrate to Thailand. Like the rest of Myanmar, Buddhists form the majority of 83.6% of the population followed by 13.0% Christians, most of the latter group come from the Karen state where they constitute a significantly high proportion of the people. There is a small proportion of Muslims, many of whom have ethnic links with the Rakhine state or Yangon. There are some distinct features in the life style of the ethnic or religious groups which should be considered in any community activities or socio-behavioural intervention programmes in the area.

Table 3.15: Ethnicity and Religion of the Respondents

Ethnicity	Frequency	%
Burmese	51	15.7
Mon	140	43.1
Karen	118	36.3
Others	16	4.9
Total	**325**	**100.0**

Religion	Frequency	%
Buddhist	271	83.6
Christian	42	13.0
Muslim	10	3.1
Others	2	0.6
Total	**325**	**100.0**

Education

Overall literacy rate is 67.6% - almost equally distributed among men and women (Table 3.16) - which is much lower than the national average of 82%. This is because of the fact that most of the people are Mon who traditionally have a lower literacy rate (also see Table 3.17). More women (42.9%) had formal primary level i.e. 1-5 years of education than men did (32.2%) , although a significant number of men (13.1%) had monastery or other forms of informal education. There is no significant difference between men and women in the secondary or higher level education.

Table 3.16: Level of Education by Gender

Education	Male		Female		Total	
Level	Number	%	Number	%	Number	%
No education*	63	31.7	42	33.3	105	32.4
1 - 5 years, primary	64	32.2	54	42.9	117	36.1
6 - 9 years, secondary	37	18.6	21	16.7	58	17.9
Over 9 years, higher	9	4.5	7	5.6	16	4.9
Unknown/others?	26	13.1	2	1.6	28	8.6
Total	**199**	**100.0**	**126**	**100.0**	**324**	**100.0**

**no formal education but some of them had monastery or other informal education;*

Among the ethnic groups, 44.2% of the Mon had no formal education compared to 33.1% of the Karen and only 4.0% of the Burmese (Table 3.17). Almost one third, 32.0% of the Burmese had a secondary level (6-9 years) education compared to only 15.2% of the Mon

Table 3.17: Level of Education by Ethnicity

Education	Burmese		Mon		Karen		Others	
Level	No	%	No	%	No	%	No	%
No education**	2	4.0	61	44.2	39	33.1	3	18.8
1 - 5 years	25	50.0	42	30.4	46	39.0	4	25.0
6 - 9 years	16	32.0	21	15.2	15	12.7	5	31.3
Over 9 years	3	6.0	3	2.2	7	5.9	2	12.5
Unknown/others?	4	8.0	11	8.0	11	9.3	2	12.5
Total	**51**	**100.0**	**140**	**100.0**	**118**	**100.0**	**16**	**100.0**

and 12.7% of the Karen. This difference in the level of education among ethnic groups could be an important factor for the knowledge of HIV/AIDS and other health issues.

Marital Status

An overwhelming 68.3% of the respondents - 69.2% men and 66.9% women - are married (Table 3.18). There is no significant difference in the marital status of men and women but most divorcees and widows are women.

Table 3.18: Marital Status and Gender of the Respondents

Marital Status	Male		Female		Total	
	Number	%	Number	%	Number	%
Single	59	29.8	32	25.2	91	28.0
Married	137	69.2	85	66.9	222	68.3
Divorced	1	0.5	4	3.1	5	1.5
Widowed	1	0.5	6	4.7	7	2.2
Total	**198**	**100.0**	**127**	**100.0**	**325**	**100.0**

Past and Present Occupations

Similar to their past, more than half of the respondents are employed in the agriculture sector (Table 3.19). From the cross-tabulation of the past and present occupations, 68.5% of the past agriculture sector workers are employed in agriculture at present and the rest are distributed in other occupations especially in fisheries, domestic service and day labouring. Many of the past unemployed (45.2%) and students (41.9%) are working in the agriculture sector, and the rest are distributed among other occupations, especially day labouring, factory worker, domestic helper and construction. Among various ethnic groups, Karen have a strong preference for agriculture (78.8%), although 47.1% of the Burmese and 49.6% of the Mon also work in the same sector. The majority, 82% of the lake fishermen are Mon. In

Table 3.19: Past and Present Occupations of the Respondents

Past Occupations in Myanmar		
Occupations	**Frequency**	**%**
Agriculture	178	54.4
Fishery	7	2.1
Student	43	13.1
Construction	4	1.2
Factory worker	15	4.6
Services/maids	3	0.9
Day labouring	25	7.6
Others	7	2.1
Unemployed	43	13.1
Total	**325**	**100.0**

Present Occupations in Thailand		
Occupations	**Frequency**	**%**
Agriculture	189	57.8
Fishery	22	6.7
Trade	8	2.4
Construction	22	6.7
Factory worker	19	6.1
Services/maids	31	9.5
Day labouring	35	10.7
Others	0	0.0
Unemployed	1	0.3
Total	**327**	**100.0**

addition 51% of the all traders and 45% of day labourers are also Mon. Burmese prefer for factory jobs after agriculture. There is no significant correlation between the duration of stay in Thailand or Thai language proficiency and selection of the main occupation of the respondents. It was not possible to include some other occupational groups in the quantitative survey such as transportation workers (pick-up and truck drivers), military and border police, other government staff, refugees, sex workers and tourist/visitors.

Thai Language Proficiency

Only a quarter of all respondents speaks moderate or good Thai (Table 3.20) which often makes it difficult for the majority to communicate with their Thai employers, co-workers and law enforcement authorities. Despite their long years of living in Thailand (Table 3.23), almost nobody reads or writes Thai. This is quite different from the Laotians and Cambodians living along the borders of Thailand, with many having better Thai language proficiency. People in the age range of 21-40 years have slightly better language skills than those younger and olders. Forty-seven percent of the women and 32% of the men do not speak Thai at all. Among ethnic groups, 33% of Mon speak good or moderate Thai compared to 15% of the Burmese and 14% of the Karen. A majority, 59% of the Karen do not speak Thai at all compared to 30% of the Mon and 33% of the Burmese. There are only a few who are fluent in reading and writing.

Table 3.20: Thai Language Proficiency of the Respondents

Proficiency level	Read	Write	Speak	Comprehension
Fluent/good	0.9	0.9	8.2	10.7
Moderate	1.2	0.6	17.1	17.1
Little	4.3	3.4	36.9	37.2
None	93.6	95.1	37.8	34.8
Total	**100.0**	**100.0**	**100.0**	**100.0**

In summary, most of the respondents are young people with mean age of 29.5 years. Male to female ratio is 61.2:38.8. A majority of 68.3% of the migrants are married and most of them live with their family. But a significant proportion of 28% single men than women are of particular concern in terms of HIV vulnerability as many of them live alone or with friends (see following sections). Ethnically, Mon and Karen are the dominant groups followed by smaller numbers of Burmese. Buddhism is the main religion of 83.6% of people but there are about 13% Christians and only a handful of Muslims. Literacy rate of 67.6% is quite low for Myanmar and is especially low among Mon at only 44.2%. Only 4.9% the respondents completed over nine years of education. There have been some changes in their past and present occupations of the migrants but agriculture remain their main occupation. Past students and unemployed migrants now have a job in Sangkhlaburi. Despite close cultural links with Thai people and long years of staying in Thailand, only smaller proportion of the migrants from Myanmar speak Thai language. This is significantly different from the migrants from Laos and Cambodia who have better Thai language proficiency. The study does not fully cover the issues of migrant children who are an important part of the migrants' demography in Sangkhlaburi.

3.6 MIGRATORY EXPERIENCE

Place of Origin

A great majority of the respondents have come from two main ethnic minority states bordering the Sangkhlaburi district (Table 3.21) i.e. Mon (47.6%) and Karen (27.6%) (Also see Map 3.2 for detailed locations in Myanmar). Only 21.9% of the respondents originate from various divisions of mainland Burma including 4.7% from Yangon and equal numbers from Tanintharyi. As indicated earlier, Mon and Karen states have a long history of ethnic conflicts with Myanmar government and as a result many of them have left home to seek refuge in Thailand. There are over 110,000 refugees in about a dozen camps along the Thai-Myanmar border. Sometimes, the refugees and migrants are mixed together as they live in the same area and have friends and relatives in the camps.

Table 3.21: Places of Origin and Intended Return of the Respondents

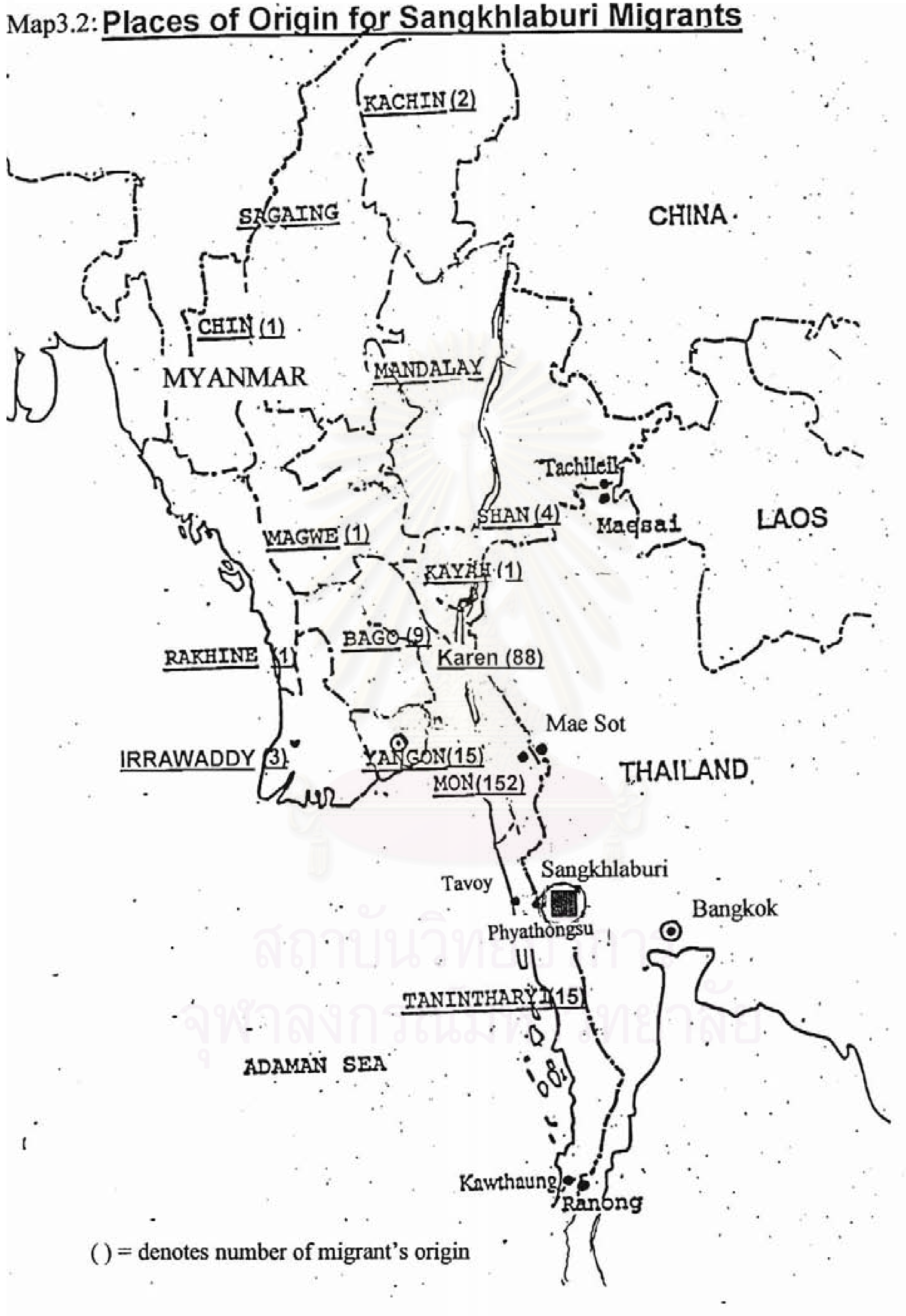
Divisions/States	Places of Origin		Intended Places of Return	
Divisions	**No.**	**%**	**No.**	**%**
Bago	9	2.8	2	0.6
Irrawaddy	3	0.9	-	-
Magwe	1	0.3	-	-
Mandalay	4	1.3	-	-
Tanintharyi	15	4.7	6	1.8
Yangon	15	4.7	3	0.9
Sagaing	-	-	-	-
Sub-Total	**47**	**14.4**	**11**	**3.4**
States				
Chin	1	0.3	-	-
Kachin	2	0.6	-	-
Karen	88	27.6	37	11.3
Kayah	1	0.3	2	0.6
Mon	152	47.6	55	16.8
Rakhine	1	0.3	-	-
Shan	4	1.3	2	0.6
Sub-Total	**249**	**75.9**	**96**	**29.4**
Unknown/missing	31	9.5	16	4.9
Stay in Thailand	-	-	204	62.2
Total	**327**	**100.0**	**327**	**100.0**

** The main Burma state of Myanmar is divided into seven administrative divisions and the remaining areas of the country is divided into seven states according to the predominant ethnic minority groups in those areas;*

Intentions and Place of Return in Myanmar

About two-thirds (67.1%) of the respondents do not intend to return to Myanmar (Table 3.21). This is because of the fact that many of them belong to ethnic minority groups i.e. Mon and Karen, and there is no clear sign for an end to ethnic conflict in their home states. It

Map3.2: **Places of Origin for Sangkhlaburi Migrants**



สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

is also a fact that many of them came to Sangkhlaburi a long time ago and are in possession of pink, orange or blue cards provided by the Thai authorities. They are probably hoping to get permanent residence status in Thailand as some other ethnic groups were granted the similar privilege in the past. Even people who came from various divisions of Burma, many of them are not willing to return. This is much different from the migrants in Ranong, a great majority of whom wish to return to their home (see Chapter 4). The distribution of those who still wish to return home are similar to that of their places of origin i.e. in the order of Mon and Karen states and other places (Table 3.21).

Reasons for Migration

There are some interesting variations for the reasons of migration to Thailand. About 90% of the ethnic Burmese came to work in Thailand compared to 75% of the Mon and 72% of the Karen (Table 3.22). A small but significant number of Karen, 12.7% and 7.3% of Mon migrated because of ethnic war in their homeland, and none of the Burmese indicated this to be a reason for their migration. Forced conscription has often been cited by human right activists to be widespread in Myanmar , but is not found to be a major factor. However, in-depth interviews with key informants show that a great majority came to Thailand because of a multitude of problems, not simply one or the other.

Table 3.22: Reasons for Migration by Ethnicity

Reasons	Burmese	Mon	Karen	Others	Total
Seek Employment	90.2	74.5	72.0	68.8	75.5
Escape War	-	7.3	12.7	12.5	8.4
Join Family	5.9	12.4	8.5	-	9.3
Escape Conscription	-	2.2	0.8	-	1.2
Other Reasons	3.9	3.6	5.9	18.8	5.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

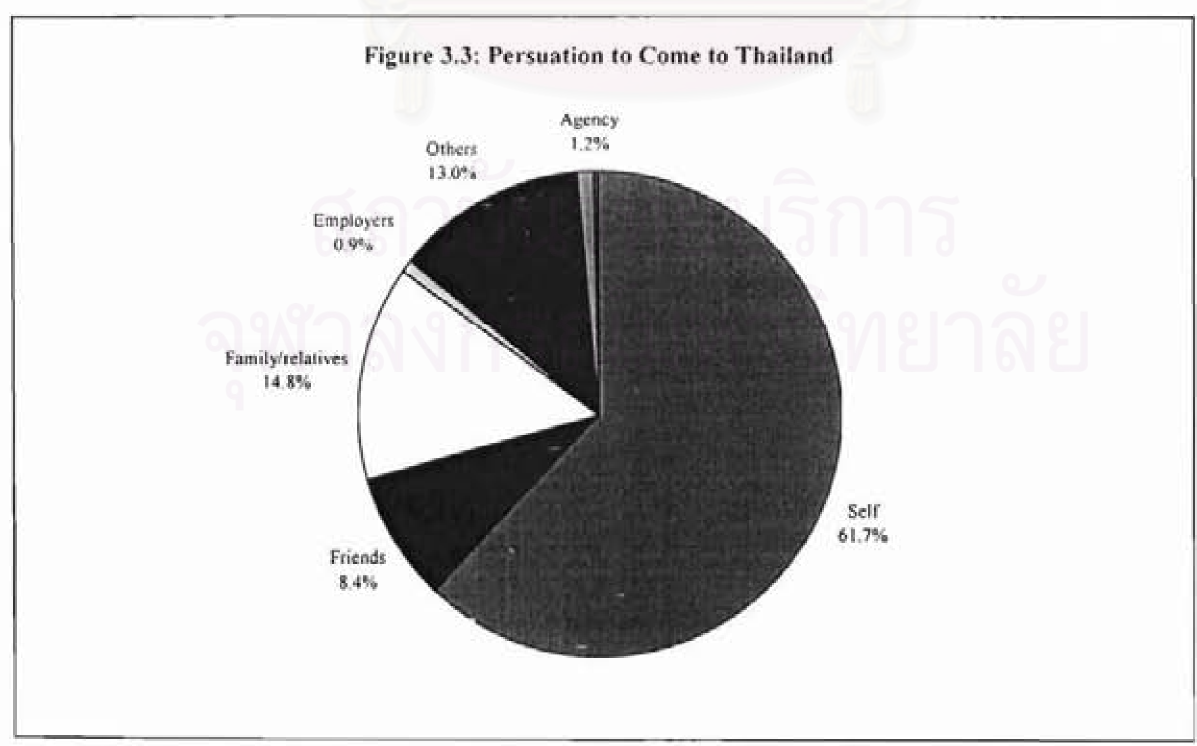
People working in the agriculture sector have been severely affected by the deteriorating economic situation in Myanmar. All farmers are required by state regulation to sell a certain amount of their rice crop calculated on the basis of acres of rice field that they cultivate. When the rice production falls short of the required quota they are obligated to sell to the government, the farmers have to buy rice from the open market and resale it to the authorities often at a much lower price. In these circumstances, their meagre income, which usually is just adequate for their own survival, drastically reduces. In addition, people from the Mon and Karen states are subject to a variety of taxes imposed by the local authorities. All of these factors have worsened the already precarious situation, which makes their lives in Myanmar intolerable. It appears that the political persecution of the Mon by the Burmese military has lessened since a peace agreement was signed between the Burmese government and the New Mon National Party in 1995. However, it did not help the farmers to improve their economic condition and their daily livelihood. A dramatic increase in the cost of living has contributed to the worsening social situation in the country. So a combination of many of these situations have caused the massive migration in lower parts of the Mon state and the Kya-Ain-Seik-Kyi district of Karen state which forms the bulk of migrants staying in Sangklaburi.

Prior Knowledge of Conditions in Thailand

A majority of 79% of the respondents did not know about the 'real situation in Thailand' before coming. Those who knew about it received the information from friends and relatives. Even then they really did not get the actual picture of Thailand such as the current economic turmoil, police and immigration crackdowns, physical and sexual abuse, and the nature of exploitation by employers. Most of the prospective migrants do not openly talk about their impending departure because they are afraid of arrest and/or extortion by the authorities. More than half of the respondents (56%) had someone in their villages who had worked in Thailand. These returnees did not, however, give an accurate account of the actual situation in Thailand, perhaps because they were too ashamed to tell what had actually happened to them. They were more interested to talk about the "good things" and "show-off" the fortunes they earned in Thailand. This is probably the reason why so many people are still migrating despite numerous reports of the migrants about raids, arrests, abuses and torture of migrants in Thailand.

Recruitment Process

When asked about who introduced them to come and work in Thailand, a great majority (65%) of the respondents claimed that they found out by themselves (Figure 3). A smaller segment said that they got help from their relatives (15.5%) and friends (8.8%). Only 0.9% stated that they had taken help from the recruitment agents in their place of origin. This claim about absence of agents could also be supported by the fact that 98.8% of the respondents never paid any agency fee for their movement up to the border. This may be true as it is very difficult for any agency to organise such trips in a country where the authorities are strongly opposed (at least in public statements) to any departure and migration out of the country. However, once they arrive at the border, many of them have to pay the usual fees to cross the border (see below) and work in Sangkhlaburi.



The situation changes quickly once they arrive at the border and want to go to destinations inside Thailand such as Bangkok, Samut Sakon, Samut Prakan etc. Here they must find agents in order not to be caught by immigration and border police who control all the major roads leading to Kanchanaburi and central Thailand. The majority of agents working in Sangkhlaburi are Mon. There are three main routes through which the agents facilitate migrants' travel to the central parts of Thailand:

- Halokkani-Sangklaburi-Central Thailand,
- Phayathongsu-Chedi-Sam-Ong-Central Thailand,
- Phayathongsu-Japanese Well-Central Thailand.

Japanese Well Village: a case study

Japanese Well Village was established four years ago just inside the Myanmar border area and is about 15 km from Chedi Sam Ong or Phyathongsu (Map 3.2). It is called after a well dug by invading Japanese troops during the Second World War. Initially opened with just four houses, the village has quickly expanded to its current population of about 2,800. Residents come from various parts of Myanmar, mostly Mon state. It is connected by a road with Thanphyuzayet, a town in the Mon state. Passenger pick-up trucks travel regularly on this road and charge about 600 Baht per passenger. The predominantly ethnic Mon population in the village who have lived under the control of the New Mon National Party for 35 years can read and write Mon but very little Burmese or other languages.

This is one of main launching points of illegal migration to central Thailand. There are a number of travel and recruitment agents in this village who arrange food, lodging, transportation and jobs for the migrants who intend to go to central Thailand. These agents have wide ranging connections with the Thai and Burmese authorities who often share the profit from these activities. The agents may have sub-agents in some places like Bangkok, Samut Sakon or Samut Prakan. They charge a fee for the transport and safe passage to the destination and a separate fee for a guaranteed job in those places.

There are a number of female migrants travelling through this renowned village. Young girls are usually preferred as domestic helpers by potential employers. Some women may have been lured into the sex business and others are seduced or even trafficked into sex and entertainment work in Thailand. Most of the men are recruited in agriculture, construction and fishery businesses. As a whole, Japanese Well plays an important role as an entry point for a large number of illegal migrants - both new and returnees - entering central Thailand. It plays a less significant role in the deportation of people.

A majority of Japanese Well villagers do not have a good knowledge about HIV/AIDS but there is a growing general perception that migrants are more at risk for HIV. Two migrant HIV-positive people from central Thailand were repatriated through this village last year resulting in much fear among residents. During the last year also two sex workers who used to work undercover were forced to leave by a village headman. One local resident summarises the situation: "Japanese Well villagers only choose to marry girls from the nearby villages. They are afraid that they may get disease (HIV/AIDS) from the migrants; especially those returning from Thailand".

The agents operating through these routes work in close collaboration with Thai border police who are responsible for the "safe passage" from Sangkhlaburi to central Thailand. The agents offer two kinds of services in Halokkani camp: (i) they arrange a trip to the central part of Thailand, and (ii) they act as a recruitment agent for some employers at the destinations. Different rates are charged by the agencies for each of these services which are shared with the police and other authorities. These agencies also offer services for the return of migrants from central Thailand to their place of origin in Myanmar via Sangkhlaburi. Agency fees range from 5,500 Baht to 14,000 Baht, sometimes paid in gold. The charges can be paid in advance or deducted from the salary after being employed. In the latter cases, the migrants are more likely to be subjected to exploitation because the employees often do not know about the agreement made between their agents and the employers. Overall, these travel and recruitment agents wield a great power over the migrants, which becomes a source of conflict between them. There are also several reported cases of conflict and fighting among these agents who compete for the control of their business.

Routes of Migration in Myanmar

Sangkhlaburi shares a border with the Mon and Karen states of Myanmar. It is also not too far from the Tanintharyi division of the Burma especially its port city Tavoy. There are four routes commonly used by migrants to travel from Myanmar to Sangkhlaburi (Map 3.2):

- Sinphytaung (northern Tanitharyi) to Phayathongsu road (via Mon state): people from the southern part of Myanmar and the lower Mon state usually use this road. It also serves as a communication route between Kawthaung and Phayathongsu inside Myanmar.

- Ye district town in the Mon state - Halokkani road: Four-wheel pick-ups transport passengers as well as manufacture goods from the Halokkani camp to Ye town. This is a very difficult road to pass. It takes about six to eight hours by a pick-up truck and two to three days walking. A pick-up truck trip cost about 600 Baht.

- Thanphyuzayet in the Mon state - Phayathongsu road: This road connects Thanphyzayet town of the Mon state and Phayathongsu which is usable throughout the year. Approximately 30 passenger pick-up trucks operate on this route. Each of the trucks can accommodate up to 20 passengers; approximately half of them are traders and the other half are migrants. This is by far the most popular route of migration to the border.

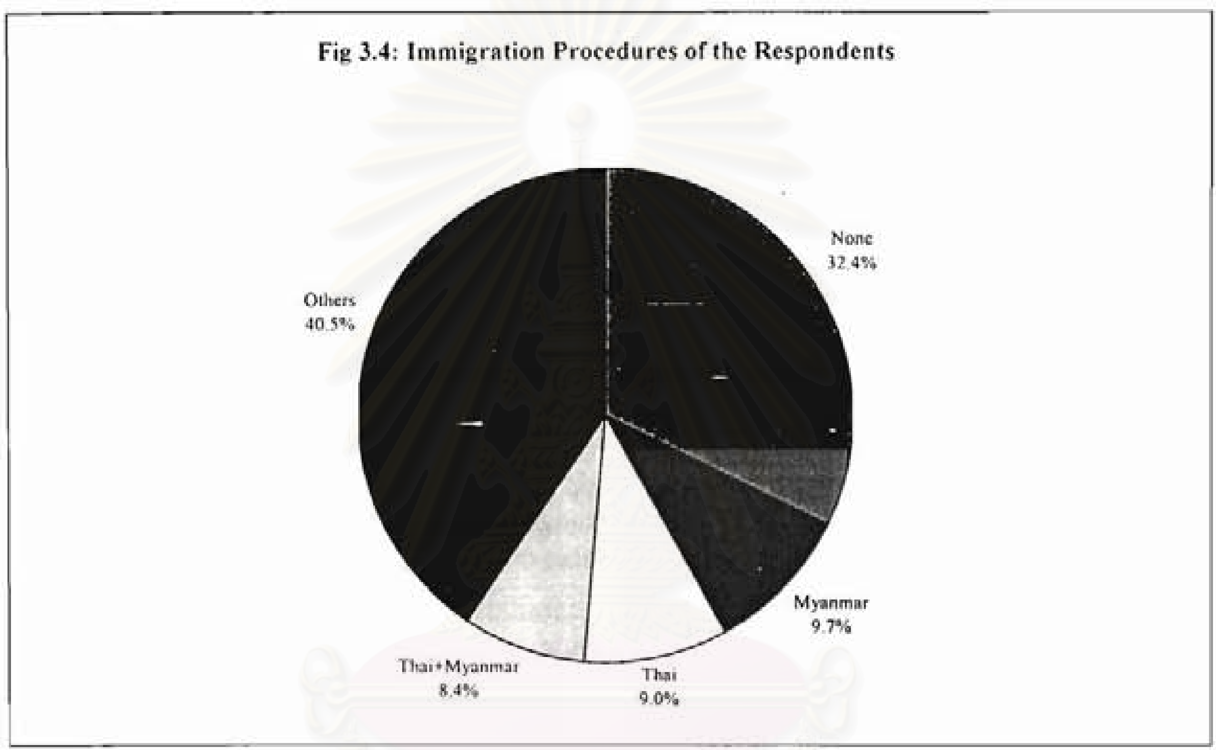
- Kya-Ain-Seik-Kyi (Karen state) Phayathongsu river: Approximately three kilometres from Phayathongsu, five small streams meet to become a small river that flows to Kya-Ain-Seik-Kyi in the Karen state and then to the Mataban gulf. Small passenger boats ply in this river during the rainy season and early winter only. The river dries up in the summer.

There are several checkpoints on these routes controlled by Karen, Mon and student groups. Most of them are very friendly and some of them provide food and first aid to migrants. Usually migrants travel in groups with friends or relatives. Endemic Malaria is the main health hazard in the area and the most common illness among the migrants.

How They Cross Border

Figure 3.4 show that 32.4% of the respondents have not gone through any immigration procedure. Only 8.4% have gone through both Thai and Myanmar immigration, 9.7% passed through Myanmar immigration and another 9.0 % passed through Thai immigration only. A large proportion, 40.5% had other local and perhaps, some special border-crossing arrangements. A significantly high proportion (40.1%) of Mon have not gone through immigration compared to smaller numbers (less than 30%) of other ethnic groups. This indicates that Mon have more informal connections with local people and authorities who help them to cross the border more easily.

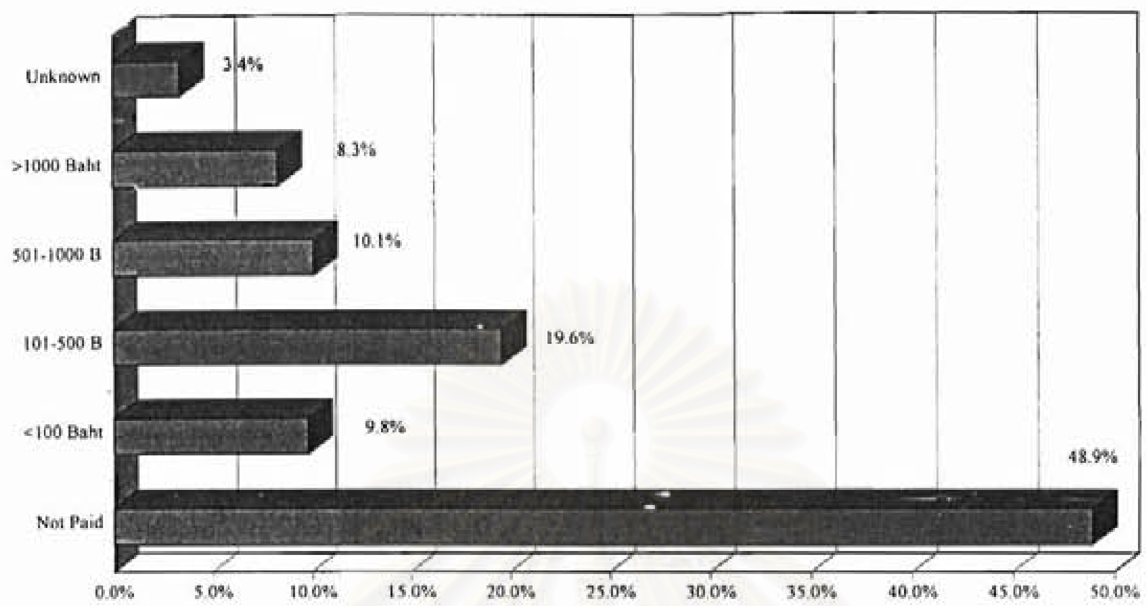
Fig 3.4: Immigration Procedures of the Respondents



Expenses to Cross Border

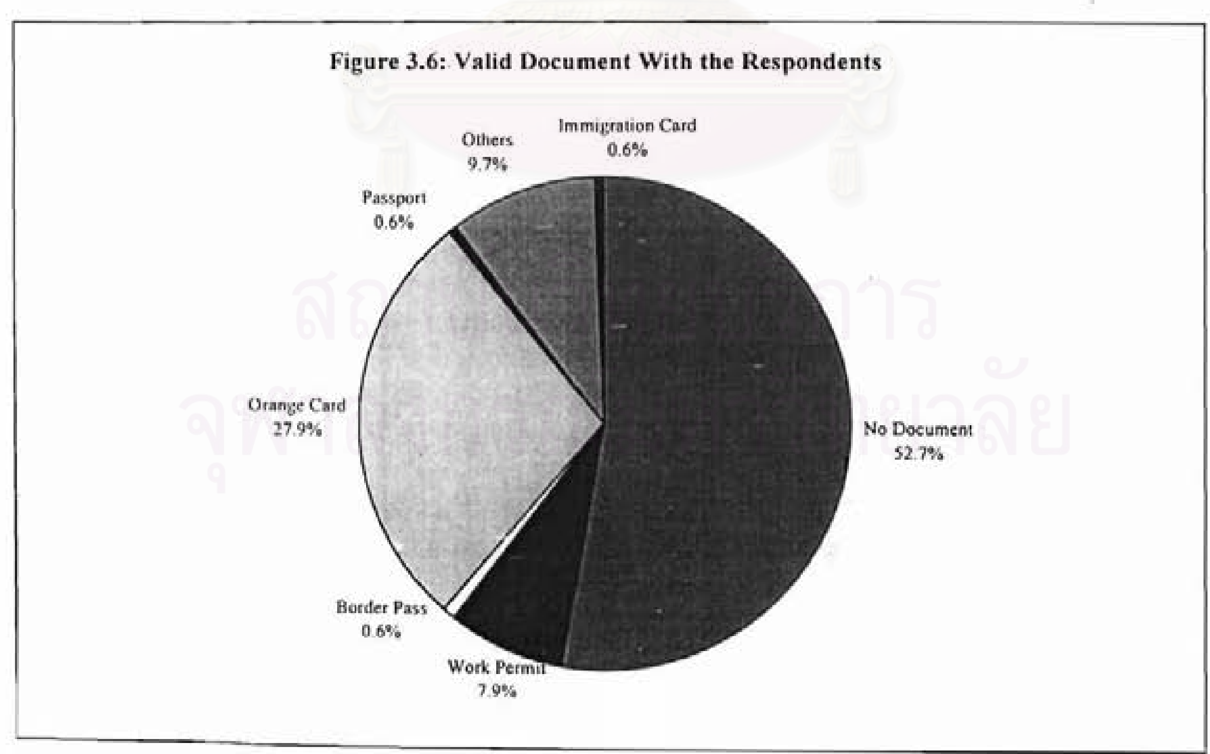
About half or 48.9% of the respondents have not paid any fee to cross the border (Figure 3.5). This is almost similar to the immigration procedures observed in the previous section. They have passed without any immigration procedures through some irregular methods. Once again, most of the Mon fall into the not paid category because of strong local connections. Among those who paid for border crossing, only 9.8% paid less than 100 Baht, 19.6% paid between 100 and 500 Baht, and another 18.4% paid more than 500 Baht. The maximum amount paid by one respondent was 18,000 Baht. This figure is rather unusual to be found in Sangkhlaburi because such a high amount is usually paid for a well paid jobs in central Thailand.

Figure 3.5: Expenses Paid to Cross Border



Valid Document

Respondents were asked what kind of valid travel or immigration documents they have in their possession. The majority of Burmese (64%) and Karen (61.4%) do not have any valid travel documents but 44.2% of the Mon have orange cards compared to 18.6% of the Karen and 12% of the Burmese. This is because of the fact that most of the Mon have been living in



the area for many years. Of the total 161 people who have travel or immigration documents, 52.2% of them are actually invalid or expired. Of all respondents, 137 or 41.9% have a Myanmar I.D card and many of them say that do not intend to return to Myanmar so it is not important to keep these cards. They are however, very interested to obtain a Thai ID card if possible.

Destination of the Migrants in Thailand:

A great majority of the respondents lived and worked in Sangkhlaburi which is evident from the fact that 51.5% of them had been staying for over five years (Table 3.23) and 27.9% of them are in possession of an 'orange card' (Figure 3.6). Many, especially Mon would like to stay permanently in Thailand if allowed to do so by the Thai government (see Figure 3.2). However, 20.7% of them have worked in other places in Thailand before coming to Sangkhlaburi. This shows the past and potential future mobility of people who are seeking better incomes and are willing to take risks in order to achieve their intended objectives.

Excluding Sangkhlaburi, there are an estimated 80,000 migrants in Kanchanaburi Province and almost all of them have passed through Sangkhlaburi district. In addition, an estimated half-a-million people from Myanmar are working in various provinces in central Thailand such as Bangkok, Samut Sakon, Samunt Prakan, Nakhon Pathom, Samut Songkram etc. Some of them even move up to the eastern provinces e.g. Rayong, Chantaburi and Trat, and work in the fishing industry, gem mining, plantation and other occupations there. Some of those migrants have passed through Sangkhlaburi. According to various sources, the number of migrants travelling to Sangkhlaburi and Thailand in general has dramatically decreased in recent years. There are three main reasons for the decline:

- The Myanmar government has imposed a new regulation, which permits only ten or more vehicle to travel in a convoy from the main towns to Phayathongsu as opposed to uncontrolled trips of the past. This delays the departure from Myanmar and decreases the number of trips by each pick-up truck. To compensate for their losses the pick-up owners have increased charges from the passengers and as a result, fewer people are travelling to the border and overall migration has decreased.

- Recent economic meltdown in Thailand has resulted in loss of jobs in certain occupations notably construction and service sector but also in some production industries. There are fewer job opportunities now than a couple of years back.

- Stringent law enforcement by the Thai immigration and police to suppress illegal migrants has also made trafficking from the border to the central provinces more difficult. This has resulted in a further reduction of illegal migration in the area.

Duration of Stay in Thailand

About half of the respondents (51.1%) have worked and lived in Thailand for more than five years and only a few (8.9%) have worked for less than a year (Table 3.23). As expected, older people have worked for a longer duration compared to the younger people e.g., 68.1% of the 31-40 years age group have worked for more than five years. The long duration of stay

is very important for the degree of familiarity with local Thai traditions and cultures as well as a closer interaction with local Thai people and other migrants in the area.

Table 3.23: Duration of Stay by Ethnicity

Duration of Stay	Burmese	Mon	Karen	Others	Total
0 to 11 months	11.8	5.8	11.3	12.5	9.1
1 to 3 years	25.5	16.1	36.5	62.5	27.3
4 to 5 years	21.6	8.8	15.7	6.3	13.2
Over 5 years	41.2	69.3	36.5	18.8	51.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

* *one missing data*

A significantly large proportion of Mon (69.3%) have stayed for over five years in Thailand compared to 41.2% of Burmese and 38.1% of Karen and 18.8% of others. There is no significant correlation between place of origin and the duration of stay. There is no gender difference for the length of stay. Of those who have lived in Thailand for more than five years, 52.6% are Buddhists, 35% are Christians. A great majority of 77% of the lake fishermen have lived in Thailand for over five years, most of whom are Mon.

Place of Living

Table 3.24 show that 41.6% of the respondents live in the Burmese community in Sangkhlaburi which is a home for the majority of agriculture workers, fishermen, traders and daily labourers. A great majority of the construction workers live in the labour houses along with some agriculture workers, factory labourers and domestic helpers or maids. Only a small proportion (3.3%) live in Myanmar and are commuting to work in Sangkhlaburi. There is no significant difference between men and women and their place of living. The place of living is very significant to determine the freedom and privacy of people at home. If they stay with their employer they remain under continuous control but if they live in their own community then they can live freely like they are used to at home.

Table 3.24: Place of Living of the Respondents by Occupation

Place of	Occupation of the Respondents							
Stay	Agri	Fishr	Trade	Const	Factr	Maid	Labor	Total
With Employer	2.6	9.1	12.5	4.5	21.1	25.8	8.6	7.3
Labour House	31.7	-	12.5	72.7	26.3	25.8	5.7	28.1
Thai Community	15.3	13.6	-	-	15.8	6.5	14.3	12.8
Burma Community	45.0	63.6	50.0	18.2	21.1	29.0	42.9	41.6
In Myanmar	0.5	-	12.5	4.5	5.3	3.2	17.1	3.3
Others	4.8	9.1	12.5	-	10.5	9.7	11.4	6.4
Total (N=326)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Mon Community: a case study

A group of ethnic Mon people live in a community near the Khao Laem dam. Their distinctive bamboo and thatch houses are clustered in this area. This community was set up before 1976. Some of the well-to-do families have simple nice wooden houses. There are a few local Thai families living in the community too which shows their close relationship with the migrants. Most of the community people work in the plantation and agriculture, lake fisheries, or do day labouring. Local government officials are the main employer in the agriculture sector and had helped the Mon to settle in the area. Those who work in the fishing industry are employed by local villagers, many of whom are ethnic Mon themselves. Some of them have small businesses and do trading with Burmese people. A few of them also work in other occupations such as in guesthouses and resorts, as domestic helpers, in the retail businesses etc. Overall, these people know where to work and earn a modest living.

Almost all community people live with their nuclear or extended family. Many of them have been living in the area for several years, and are in possession of 'pink' or 'orange' cards. Many have children born and brought up here. They go to Thai schools and study in Thai language. They are well adapted to the local situations and hope to live in the community for a long time. So they are willing and interested to develop their community and usually take part in the community activities. The main centre of the community activities are temple and religious festivals. A Mon monk who has been living in the area for a long time provides moral and spiritual guidance to this predominantly Buddhist community. He also organised to build a wooden bridge to cross a stream that has become a symbol of cohesion of the community. The villagers often join together to raise fund to repair or expand the temple.

They have very basic living conditions with reasonable sanitation and a very good natural water supply from the lake. Most of the houses have electricity and few others use kerosene lamps. Some of the houses have radio and television. The villagers are not so keen on 'so called' modern entertainment such as karaoke or beer bars. Some of them, especially the older people, drink local liquor with friends and peers. There is not much commercial sex activity in Sangkhlaburi and the Mon community people are not usually involved in it. However social and emotional relations among people are very strong. The people especially men are not so rigid about pre- and extramarital sex. "This is natural to happen in some people" says a middle-aged man, and then he adds, "may be more common among widowed and divorcee women". People in this community are not so familiar with HIV/AIDS as they have not seen any one who has it. But some people suspect that there might be a few HIV positive around. When asked what they would actually do if they find out someone in their neighbourhood or community has AIDS, there was a long silence. "I think we are not ready for it. I just don't know what to do with him/her."

Living With Whom

Table 25 shows that 58.9% of the respondents live with their nuclear family and another 22.1% with their compound family and/or relatives. Traders are more likely to stay alone or with their friends. A large proportion of factory workers (42%) stay with friends of the same sex possibly because many of them are single young men and women. Overall only 3.2% of the female respondents live alone compared to 8.5% of their male counterparts. Over 15% of

the single respondents stay alone compared to 3.2% of their married counterparts. More than a quarter, 26.4% of the single respondents stay with their same sex friends compared to 3.2% of the married counterparts. The presence of family members is often an important "social control" over people's sexual behaviour especially to those who live outside of their wedlock or are separated from their "partners".

Table 3.25: Living Circumstances by Occupation

Living With	Agri	Fishr	Trade	Const	Factr	Maid	Labour	Total
Stay alone	5.3	-	37.5	9.1	-	16.1	2.9	6.4
Nuclear family	69.1	72.7	12.5	45.5	5.3	41.9	57.1	58.9
Family and Relatives	20.2	18.2	25.0	18.1	47.4	22.2	22.8	22.1
Friends (M + F)	1.1	-	12.5	4.5	5.3	6.5	8.6	3.1
Friends (same sex)	4.3	9.1	12.5	22.7	42.1	12.9	8.6	9.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Income, Savings and Disposable Cash

There is a significant income level gap between Myanmar and Thailand. The mean monthly income in Myanmar is 439.3 Baht compared to 1,938.4 Baht in Thailand. However, one must take into consideration the purchasing power parity (ppp) of income as the cost of living is much different in these two countries. The percentage of unemployed respondents was 57.2% in Myanmar, and of those who had a job, most of them were earning less than 500 Baht a month (see Figure 3.7). In Thailand, most of the respondents are earning between 500 and 4,000 Baht a month. This level of income explains why undocumented migrant workers are migrating to Thailand despite difficult working conditions, and widespread

Figure 3.7: Monthly Income in Myanmar and Thailand

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

abuse and exploitation because of their illegal status.

Despite the significant difference in income levels between Myanmar and Thailand, 84.1% of the respondents claimed that they are not able to save enough money. Unstable or temporary job conditions are cited as the main reason followed by high costs of living in Thailand. Only 3.7% of the respondents were able to save more than 5,000 Baht a year. They usually keep money with themselves while a few keep money with the employers or others.

The majority, 82.6% of the respondents, never sent money to Myanmar. Only 4.5% sent over 5,000 Baht and 1.2% sent over 10,000 Baht in the last year. This significantly low remittance is probably due to the presence of the nuclear and/or extended family with them. Only 2.7% of the respondents have sent any precious things to their families and relatives. The situation might be different for people who go to work in central Thailand where they earn and save more money.

Rest and Recreation

Lack of rest and recreation has been cited as one of the main reasons for the loneliness and boredom among migrants and the consequent development of high risk behaviours for HIV/AIDS. Almost half, 44.9% of all respondents spend their leisure time by meeting friends and relatives in the area (Table 3.27) which is true for most of the occupational groups except traders (12.5% only). In this rural setting, there are only a few things one could do in leisure time. Men and women, single and married respondents usually do the same things. Watching television is the second most common form of entertainment (16% of total respondents). However, more women prefer to watch television whereas men prefer to watch videos, often in the video houses. Television is favoured by fishermen (36.4%), day labourers (31.4%), servants and maids (25.8%) as well as traders (25%). Mon and Karen are more interested to television than Burmese who prefer sports. Only a few people in the agriculture and construction sector watch television because they do not have access to it.

Table 3.27: Rest and Recreation by Occupation

Rest and Recreation	**Occupation of the Respondents**							
	Agri	**Fish**	**Trade**	**Const**	**Fact**	**Serv**	**Labour**	**Total**
Stay home	15.5	13.6	25.0	13.6	10.5	9.7	11.4	14.2
Games and sports	7.5	13.6	-	9.1	10.5	9.7	5.7	8.0
Watch television	9.6	36.4	25.0	9.1	15.8	25.8	31.4	16.0
Meet relatives	50.8	22.7	12.5	45.5	42.1	35.5	42.9	44.9
Drink alcohol	4.3	4.5	-	13.6	-	6.5	2.9	4.6
Watch video	7.5	4.5	-	-	5.3	9.7	2.9	6.2
Go to tea shop	0.5	-	12.5	4.5	-	-	-	0.9
Entertainment etc	1.1	-	-	-	-	-	-	0.6
Others	3.2	4.5	25.0	4.5	15.8	3.2	2.9	4.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Only 4.6% of all respondents drink alcohol in their leisure time, which is more prevalent among construction workers (13.6%), most of whom are older men. Overall, there is no significant difference among various age groups except for drinking. Very few people visit teashops and entertainment places such as karaoke or beer bars that are related to high-risk behaviour for HIV/AIDS transmission.

Table 3.28: Rest and Recreation by Age Groups

Rest and Recreation	Age Groups of the Respondents				
	<21 yrs	21 - 30	31 - 40	> 40 yrs	Total
Stay home	13.3	16.5	11.7	13.2	14.2
Games and sports	11.7	9.8	5.3	2.6	8.0
Watch television	16.7	19.5	8.5	21.1	16.0
Meet relatives	45.0	39.1	52.1	47.4	44.9
Drink alcohol	-	3.8	5.3	13.2	4.6
Watch video	5.0	6.0	8.5	2.6	6.2
Go to tea shop	1.7	0.8	1.1	-	0.9
Entertainment etc	-	-	2.1	-	4.6
Others	6.7	4.5	5.3	-	4.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Community Activities

Community activities in this predominantly Buddhist community often entail temple and religious ceremonies. People join together during these occasions to raise funds for the monks and temples. Figure 3.8 reveals that 40.5% of the respondents often participated in community activities, another 45.4% rarely did so, and, 14.1% of the respondents never

Figure 3.8: Participation in Community Activities

participated in any community activities. There are significant differences in community participation among various ethnic groups: 55.4% of the Mon often participate in community activities compared to 18.0% of the Burmese and 34.2 of Karen. Similarly 26.0% of the Burmese never participated in any community activities compared to only 8.6% of the Mon. Overall good participation of the Mon in community activities may be an important factor for community-based HIV/AIDS prevention programmes as well as the care of people with HIV/AIDS and other social issues. There is no significant difference between men and women or their marital status. However, older people are more likely to go to these community activities than the younger ones. Among religious groups, 44.2% of the Buddhists join the community activities compared to 23.8% of the Christians. Community activities in many rural settings are a good indication of people's collaboration and local religious leaders often play a crucial role in the activities.

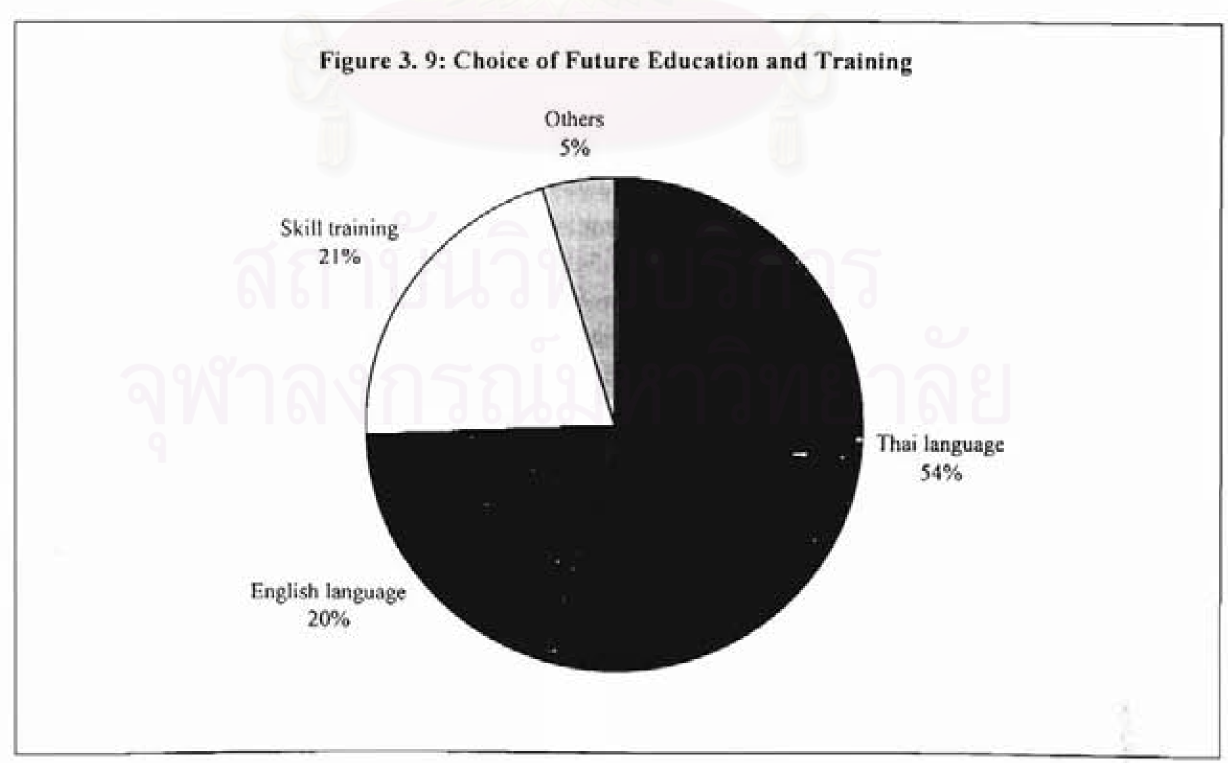
Visit to Home in Myanmar

An overwhelming 75% of the respondents never visited home since they came to Thailand. Only 9.3% visited home during the last year, 9.8% during the last two years, and 5.9% during the last three to five years. Most of the Mon never visited home mainly because their families stay with them. Visiting home therefore is not one of their priorities; they are more concerned with their new life in Thailand and the improvement of their living conditions.

Looking to the Future

The respondents were asked what they will do if they could save more money, most of them answered that they would like to support their families and relatives in Myanmar who are going through severe economic hardship. A great majority (70%) have also expressed interest in further studies and training if they can afford to do so (see Figure 3.9). Among

Figure 3. 9: Choice of Future Education and Training



future education and training, 54% prefer to study Thai, which they assume will help their living and job prospects in Thailand. This fact is considered to be an indication of their interest to stay in Thailand for a longer period of time. As indicated earlier, migrant children are attending Thai schools, which is very helpful for their eventual integration into Thai society. Other respondents have, however, expressed interest in skill training (21%) and in learning English (20%).

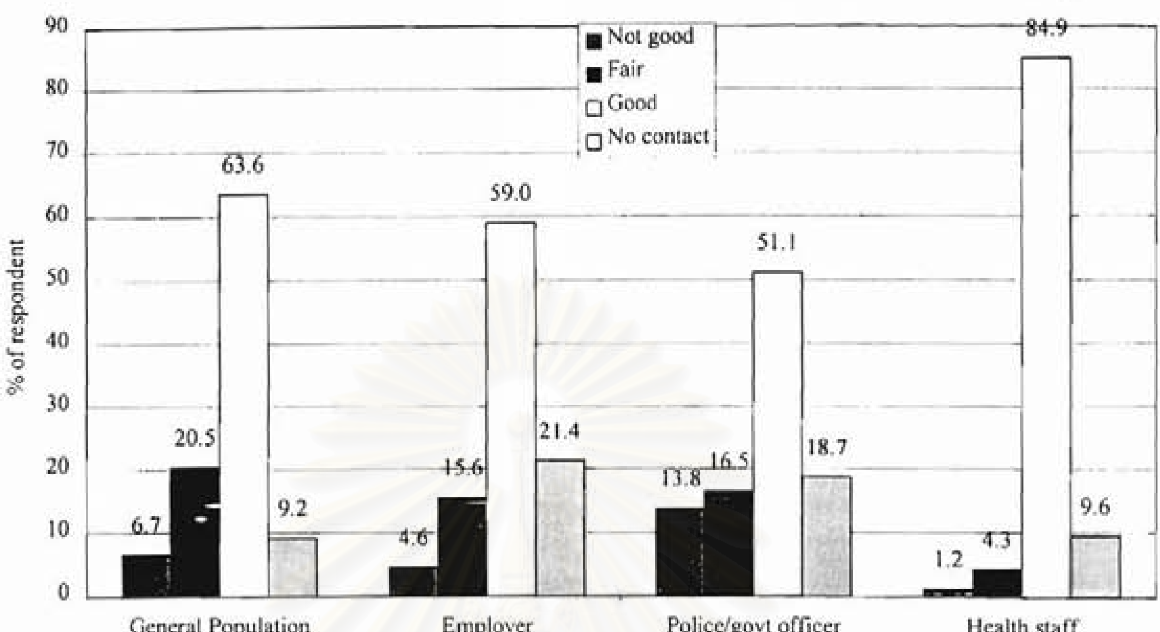
Given a choice, 62.5% of the respondents plan to continue living in Thailand and the remaining 34.8% want to return home. There are a few interesting findings about the decision making process. Fewer Burmese (39.2%) prefer to stay in Thailand for long compared to 69.3% of the Mon and 68.4% of the Karen. Older people are more likely to stay in Thailand while the younger people prefer to return to Myanmar. Those with no formal education are more likely to stay in Thailand than those with higher education. There is no significant difference among men and women about the decision to stay and there is no correlation with religious groups. People who spent more than five years in Thailand have a stronger preference to continue living in Thailand compared to those who arrived during the last three years.

If they were able to choose, 64.4% of the respondents expressed a preference to have their family stay with them in Thailand, which signifies a long-term intention to live and work in Thailand. In fact, a great majority already has their families in Sangkhlaburi (Table 3.25). The remaining 35.6% wish to visit their families in Myanmar more often, and do not want to bring them to Thailand. These findings are consistent with the previous question concerning their desire to continue to live in Thailand. The migrant population in Sangkhlaburi are quite interested in long-term settlement which is quite different from other cross-border locations e.g. in Ranong they are interested in the short-term employment and income rather that to seek long-term settlement in Thailand.

Attitude Towards Thai Officials and People

In general, migrants have a love and hate relationship with the local people. The migrants need the local people to secure their jobs and incomes, and yet they have to face many difficulties and at times even abusive treatment from the locals. Respondents were asked to express their opinion about Thai people in general, employers, health officials, police and government officials. Overall, more than half of them have rated all four categories as good, among which Thai health officials received the highest score with 84.9% approval rate and police/government officials received the lowest score with an only a 51.1% approval rate (Figure 3.10). Local officials were rated as "not good" by 13.8% the respondents. Interestingly, 59.5% of men have rated Thai police and authorities as good compared to only 37.8% of women. This might have resulted from the ill-treatment they have received by the authorities (see section on Deportation). Women are also less likely to contact Thai authorities for any reasons. Younger respondents have more of a disliking towards Thai people and authorities than the elders. The people who have been staying in Thailand for longer than five years had a better approval rating for Thai people and Thai authorities than the relatively new arrivals. The former group speaks better Thai and have adapted well to the local situation and lifestyle.

Figure 3.10: Attitude towards Thai authorities and people



In summary, most of the migrants in Sangkhlaburi have come from the neighbouring areas of Myanmar i.e. Mon and Karen State. Reasons for their migration are complex and constitute various social, political and economic hardship that they are experiencing in their country. At least some them left home because of the fighting and many have links with the refugee population living in the area. Before coming to Thailand, many of them didn't have clear knowledge about the conditions in Thailand. In most instances, they made their own decisions about coming to Thailand through informal information from their and friends and relatives as there is no organised travel or recruiting agents who could possibly help them with information. More than half of the respondents have neither immigration card nor valid work permit. About a quarter have 'orange cards', some have work permits and others have valid documents. Most of the respondents did not pay anything to cross the border while the others paid an average 100-500 baht for the purpose. About half of the respondents (51.5%) have lived in Thailand for more than five years which is more common among Mon than the Karen and Burmese. This shows the lingering ties between migrants and the local population in the area. Most the migrants have very poor living conditions, sometimes provided by their employers. Usually migrants prefer to live in one of the several communities in the district. Although the physical conditions in these communities are no better than those provided by their employers, they find it more comfortable among their own people and families. A majority 81% of the respondents live with their nuclear or compound families, and 57% of them have children born in Thailand. Many of these children are going to Thai school and studying in Thai.

Coming from predominantly rural socio-economic conditions most of the migrants still live a very simple rural life. They spend their leisure time by meeting friends and staying home. Some people watch television. Drinking alcohol and taking drugs is not a major problem. Many migrants especially Mon join in various form of temple and other community activities often in their own community but also with their Thai neighbours. These community activities help them to develop their sense of pride and dignity, and at the same

time build closer interactions with the local people. In general, most of the migrants have rather good attitude towards the general Thai population, their employers and health officials but many migrants have a strong disliking for Thai police and immigration officials because of the mistreatment they endured in their hands. A great majority of migrants never visited home since they came to Thailand but do not intend to return home. Most of them hope to live permanently in Thailand and devoting time and energy in building their new home.

FINDINGS ON HIV/AIDS RISK SITUATIONS

This section covers knowledge, attitude and practice relevant to HIV/AIDS situation in the study site. It addresses the basic questions of 'ever heard about AIDS' and 'ever heard of STDs', examines their knowledge and misperceptions of HIV transmission, the symptoms and cure of HIV/AIDS and the testing methods. It further elaborates on the knowledge and misperceptions of HIV prevention, their specific risk behaviours, attitude towards people living with HIV/AIDS (PWHAs), and finally a self-assessment of their HIV vulnerability. The variables from the demographic information and the migratory experiences are systematically tested in order to determine significance and relevant correlations.

3.7 KNOWLEDGE AND AWARENESS OF HIV/AIDS/STDs

Design and Methods of Analysis

Altogether the following five aspects of HIV/AIDS knowledge are chosen for systematic analysis. The first two deals with single questions (1 & 2) about symptoms and cure of HIV/AIDS. The other three are number of questions grouped together (3, 4 and 5). In addition to usual frequencies and cross-tabulations, the latter three groups of questions (3, 4 & 5) have also used a scoring method (see Chapter I) which allowed for comparing means through the one-way ANOVA. The five areas of knowledge questions are as follows:

Knowledge on symptoms, testing and cure of HIV/AIDS

1. Do people with HIV/AIDS have to have symptoms?
2. Can AIDS be cured?
3. Two questions on methods of HIV testing;
   Six questions on signs and symptoms of HIV/AIDS;

Knowledge and misperceptions of transmission

4. Eight questions on modes of HIV transmission;
   Six questions on misperceptions of transmission;

Knowledge of HIV prevention

5. One question on the prevention of HIV by use of condom;
   Five questions on the myths and misconceptions of HIV/AIDS prevention;

As indicated above, demographic and migratory experience variable in the previous two sections are systematically analysed against all five areas of questions. Some of the large and sometimes unrelated sub-groups of questions are analysed separately before performing the total group analysis. For example, in the "knowledge and misperceptions of transmission", the combined large group of 14 questions is broken down into two sub-groups - one sub-group of eight questions on the "mode of transmission" and another sub-group of six questions on "misperceptions of transmission". This has allowed a better understanding of

the actual situation, whether the overall knowledge is influenced by a lack of knowledge or misperceptions about transmission or both.

Further analyses are made about people's responses towards sexual behaviour and acceptable norms, as well as some of the masculine behaviours relevant to HIV risk situations. Analyses are also done on the specific risk behaviours and prevention practices such as alcohol and injecting drugs and substance use, unsafe sex practices including commercial sex, and blood transfusions. A short paragraph is given on the respondent's self assessment of HIV vulnerability. Last but not least, an analysis is given on the respondent's attitude towards people living with HIV/AIDS (PWHAs) which has become an important social, economic and political issue as the epidemic is growing and the number of AIDS cases are increasing all over the region.

Heard of AIDS - Through What Means?

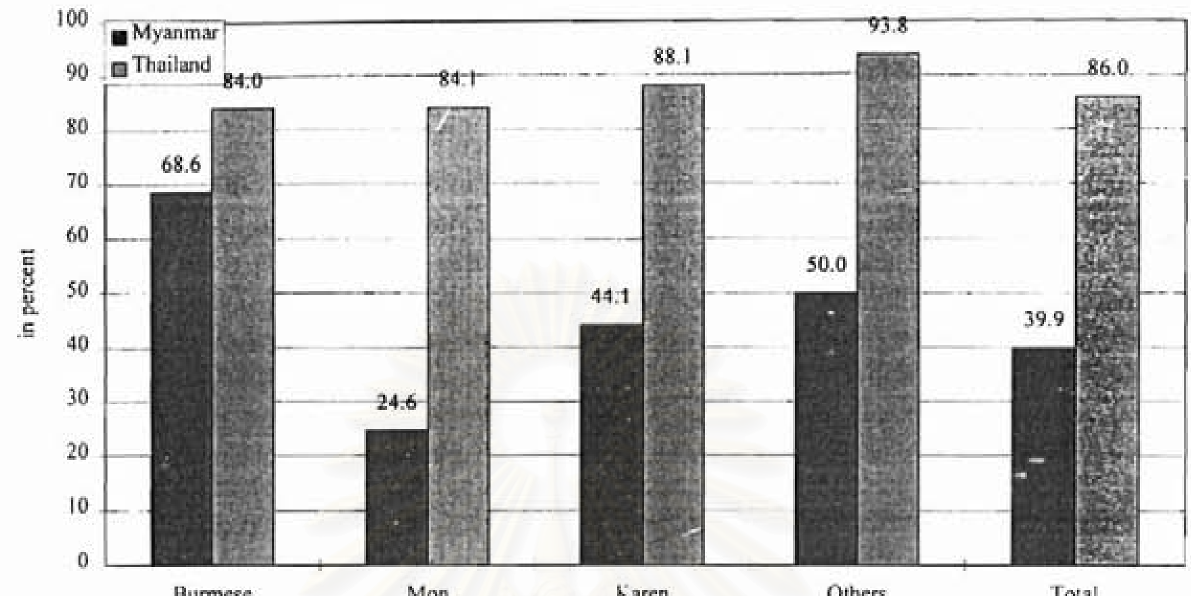
Before coming to Thailand, few people (40.0%) had heard about AIDS in Myanmar (Table 3.29). There has been an increased awareness of up to 86.2% of respondents after they have arrived Thailand. Overall, 90.5% of respondents had heard about AIDS in either Myanmar or Thailand and 35.7% have heard about AIDS in both countries. This apparent low level of response in Myanmar is due to the fact that many migrants came to Thailand a long time ago when HIV/AIDS awareness in Myanmar was not as good as it is today; 51.5% of the respondents have lived in Thailand for more than five years, and 75% of all respondents have never returned home. Thus, they have learned about the disease in Sangkhlaburi or elsewhere in Thailand. Overall, only 9.5% of people did not hear about AIDS neither in Thailand or Myanmar. This appears to be an overall good picture compared to the situation in many border areas in Myanmar and generally poor awareness campaigns in many parts of the country.

Table 3.29: Heard About AIDS in Myanmar and Thailand

		THAILAND		
		No	**Yes**	**Total**
MYANMAR	**No**	**9.5**	**50.5**	**60.0**
	Yes	**4.3**	**35.7**	**40.0**
	Total	**13.8**	**86.2**	**100.0**

Fewer Mon knew about AIDS in Myanmar compared to other ethnic groups (Figure 3.11). There is no significant difference in AIDS awareness among ethnic groups after they arrived Thailand. Overall only 6.6% of the male respondents had never heard about AIDS compared to 14.2% of their female counterparts. This gender difference is prevalent in Thailand too where 17.3% of women did not hear about AIDS compared to 11.6% of men. There was no significant gender difference, however, in Myanmar. In general, women in rural communities have relatively less access to information and media compared to their male counterparts. Of those with no formal education 18.1% did not hear about AIDS compared to 10-12% of those with formal education. There is also a significant difference between the religious groups where more Christians have heard about AIDS than Buddhists.

Figure 3.11: Heard of AIDS in Myanmar and Thailand by Ethnicity



Most of the people who heard about AIDS did so by talking to someone else in either Thailand or Myanmar (Table 3.30). While it is an encouraging sign that people are actually talking about AIDS, one should be very careful about the content of information they are talking about. It has been found in many situations that people are in fact getting wrong information through informal channels which is reflected in the misperceptions about the disease as well as PWHAs. Despite wide ranging coverage about HIV/AIDS on Thai television and radio, only about a third of the respondents received message from the media. Many of the respondents do not have access to TV, and they also do not understand Thai language. Some poster and billboards are appearing and at least 22.6% claimed to have noticed some of the messages.

Table 3.30: How Did They Hear About AIDS

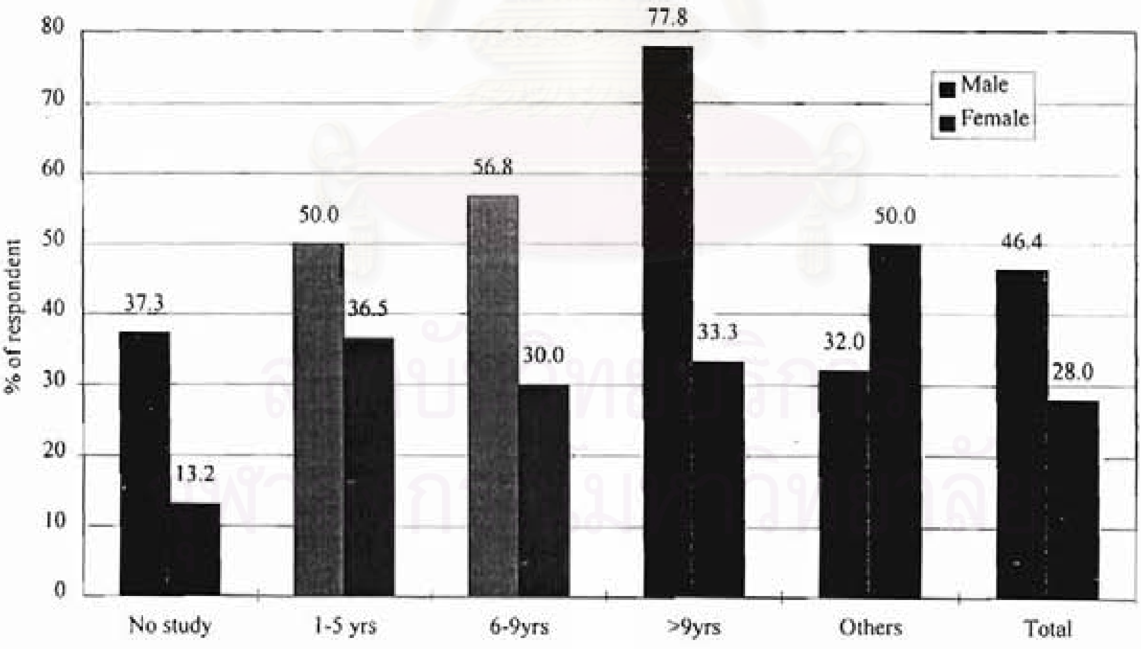
Through What Means?*	In Myanmar (N=131)	In Thailand (N=280)
Talking to people	87.8	88.6
Television/radio	38.2	39.6
Newspapers	19.8	10.4
Posters/billboard	23.7	26.4
Health officials	9.9	11.4
Teachers/school	9.2	0.4
NGO workers	2.3	2.9

* *multiple answers allowed;*

Heard of STDs - Through What Means?

STDs are known to be closely linked to HIV transmission. It is therefore very important to gauge the knowledge of STDs for HIV/AIDS risk situations. A surprisingly low proportion of respondents, 37.2%, had heard about STDs either in Thailand or Myanmar, or both. This percentage is much lower than the 90.5% who had heard about AIDS. One explanation for that fact is that people know about individual STDs such as gonorrhoea or syphilis, but not so much about STDs as a group of diseases. Another possible reason is that there could be low prevalence of STDs in the community and therefore not much public health education is given to this. Talking about sex is taboo in many cultures and sexual problems usually are not discussed with others. A significantly low number of women (28.0%) have heard of STDs compared to 46.4% of men with no significant difference in their marital status. People who have a higher education know much more about STDs than people with no formal education. There is no significant difference among ethnic groups. Among religious groups, 56.1% of the Christians compared to only 35.9% of the Buddhists have heard about STDs . Very young people, i.e. aged less than 20 years are slightly less aware (29.6%) compared to about 40% of the other age groups. No significant difference was found among occupational groups but traders, however, are slightly more aware than others are, with most belonging to higher income groups. Newcomers have little knowledge about venereal diseases. Contrary to our expectation, there was no significant difference among people who speak Thai and those who do not.

Figure 3.12: Heard About STDs by Gender and Age



Only five out of 327 respondents reported to have suffered from any kind of STDs for which they received treatment in Thai hospitals or clinics during the last year. There are no other sources of information for the existence of STDs in the community especially not for women who are more affected by non-gonococcal urethritis, trichomoniasis or candidiasis. If we can assume this to be a true reflection of the STD situation, the population indeed has a very low

prevalence of venereal diseases. Sangkhlaburi district hospital recorded 13 VRDL positive Syphilis out of 855 tests in 1998, three out of 835 in 1996, and only one out of 110 in 1997. However, these test results do not provide any clear indication of the actual STD prevalence in the area. STD data from the Christian Missionary Hospital, private clinics or drug stores are not available. Overall, not much is known about the STD situation in this community and further investigations are needed to come up with a realistic picture.

Knowledge of HIV Transmission

Knowledge of HIV transmission is key to the understanding of the natural history of the disease and people's perception about it. The following eight questions in Table 3.31 were asked to test study population knowledge. About two-thirds of the respondents chose the correct answer for the three main modes of HIV transmission, i.e. heterosexual intercourse (65.5%), sharing needle for injection (63.3%) and receiving blood transfusion (58.5%). Less than half of the respondents could give the correct answer for other modes of transmission such as anal or oral sex, deep kissing or sharing blood stained razors and knives. There are a lot of "unsure" answers about modes of transmission, which signify a great amount of uncertainty. All of the results point to the fact that the majority of the respondents have not received reliable HIV information by talking to others.

Table 3.31: Knowledge of HIV Transmission

Possible Transmission by	Agree	Disagree	Don't know	Total
Heterosexual intercourse	65.5	2.7	31.7	100.0
Homosexual intercourse (man to man)	38.7	13.1	48.2	100.0
Anal sex (man to woman)	39.0	4.9	56.1	100.0
Oral sex (man or woman)	34.5	10.1	55.5	100.0
Deep kissing (mixed with saliva)	19.3	32.7	48.0	100.0
Receiving blood transfusion	58.5	5.9	35.6	100.0
Sharing needle for injection	63.3	4.0	32.7	100.0
Sharing (blood stained) razor/knives	55.7	7.4	36.9	100.0

Misperception of HIV Transmission

Misperceptions of HIV transmission are abundant among the respondents (Table 3.32). This ranges from 48.6% believing that mosquito bites transmit HIV to 40.1% believing that sharing a toilet or a bathroom would transmit HIV, 36.7% claimed that HIV could be transmitted by sharing clothes and 35.2% have identified eating and drinking with HIV-positive people as a mode of transmission. A high proportion of 20.4% of the respondents believe that HIV could be transmitted by simply touching the HIV/AIDS patient. A very large segment of the respondents are "unsure" about the modes of transmission, which again signifies a high degree of uncertainty. Only a smaller proportion of respondents disagrees with the casual modes of transmission of HIV/AIDS.

Table 3.32: Misperception of HIV Transmission

Possible Transmission by	Agree	Disagree	Don't know	Total
Touching HIV/AIDS patient	20.4	38.9	40.7	100.0
Sharing eating and drinking	35.2	26.5	38.3	100.0
Sharing toilet/bathroom	40.1	21.9	38.0	100.0
Sharing clothes	36.7	24.1	39.2	100.0
Mosquito or insect bites	48.6	14.2	37.2	100.0

The mean of the misperceptions are analysed against demographic and migration variables by one way ANOVA. There is no significant difference between various age groups, gender, marital status, or ethnic groups. The Mon, however, have more misperceptions than the Burmese. No significant difference exists among the different religious groups but Buddhists have a few more misunderstandings than the Christians do. People with no formal education showed significantly more misunderstandings than those who had primary or secondary level education (1-5 years and 6-9 years). However, people with high school or higher education did not show any significant difference to those without education. No definitive correlation was found between the duration of stay in Thailand and the misperceptions. Generally, people who speak better Thai had a clearer understanding of the situation due to the fact that Thai speaking people had better access to the Thai information and media campaign. There was no significant difference among various occupational groups but detailed analysis showed that fishermen and agriculture workers have more misunderstandings than those working in factories, service and trading businesses. These latter groups of people have more income and usually a higher level of education.

It should be emphasised that many of the misunderstandings and discrimination against PWHAs originates in the misperceptions about the modes of HIV transmission. It is therefore of utmost important that an HIV/AIDS prevention and care projects raise awareness about these misperceptions with an equal strength as to the modes of transmission. The projects could also actively demonstrate its target audience that casual contacts with PWHAs do no cause any harm. These forms of educational projects are expected to help build an enabling environment for the care and support of the PWHAs.

In summary, overall knowledge of HIV transmission has no correlation with age, gender, marital status, ethnicity and duration of stay in Thailand. There is, however, a significant difference between two main religious groups, i.e. that Christians have a better knowledge of modes of transmission than Buddhists. There also is a significant difference between respondents who had more than nine years of education and all other groups, especially those without any education. Respondents who speak good Thai have a significantly better knowledge of HIV transmission modes than those who do not speak Thai. Finally, there is no significant difference among various occupational groups but service workers, maid and factory workers have a slightly better knowledge than the fishermen and agricultural workers. This also coincides with the fact that people who earn more than 4,000 Baht per month have a better knowledge than those with less than 500 Baht income. The latter income group mainly belongs to the agriculture sector and fisheries.

Knowledge of Symptoms, Testing and Cure

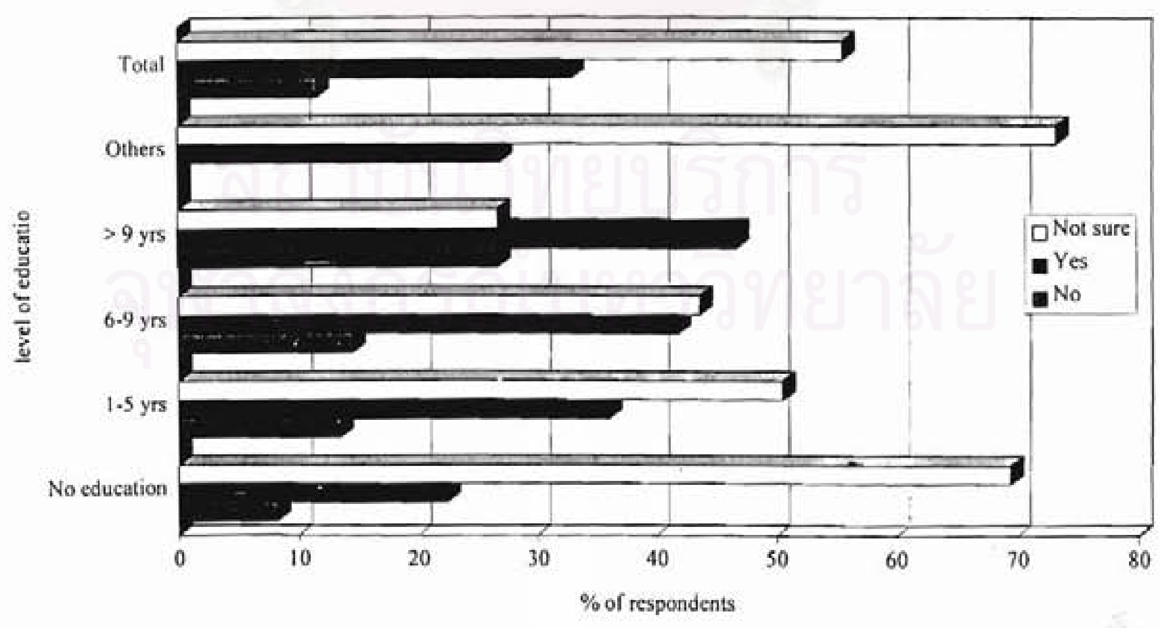
In this section, the respondents' knowledge about symptoms, HIV testing and treatment are analysed by the one-way ANOVA against demographic and migration variables. At the same time, the individual questions about "HIV/AIDS patients could have no symptom" and "there is no cure for AIDS" are analysed by simple frequencies and cross-tabulations.

Knowledge of HIV/AIDS Symptoms

Respondents were asked the critical question whether some people with HIV/AIDS could have no symptoms. An overwhelming 55.5% were unsure about the answer which signifies their great uncertainties (Figure 3.13). Only 32.9% have responded that they could be without symptoms and the remaining 11.6% said that they should have symptoms. The nature of the disease with its long incubation period of eight years or more keeps the disease "out of sight" of many and might be an explanation for above responses. Once again, the natural course of the disease is one of the key information that HIV/AIDS projects should emphasise on.

Figure 3.13 also shows that people with six to nine years or over nine years of education have a better knowledge of HIV symptoms (41.8% and 46.7% respectively) compared to only 22.4% with no formal education. Conversely, 69.4% with no formal education are unsure about HIV symptoms compared to only 26.7% with more than nine years of education. Surprisingly, 26.7% with more than nine years of education have given wrong "no" answers compared to only 8.2% of those with no formal education. This might be due to the fact that better educated people tend to express their opinions - right or wrong - more than uneducated people who rather tend to keep quiet.

Figure 3.13: HIV/AIDS Patients Could Have No Symptom by Age



There is no significant difference among various age groups, although 47.3% of those under 21 years of age are unsure about the question compared to 66.7% of those over 40 years of age. No significant difference is found among ethnic groups. Among religious groups, 60.1% of Buddhists are unsure compared to only 31.7% of Christians. A majority of 56.1% of Christians also has agreed that some HIV/AIDS patients could be without symptoms compared to about 28.6% of Buddhists. More single people have "yes" answers (46.0%) to the question compared to 27.8% of the married ones. There, however, is no significant gender difference among them. Only 22.6% with no Thai language ability answered "yes" compared to 37% with moderate and 34.6% of those with good Thai knowledge. There is no significant difference among various occupational groups, income levels or lengths of stay in Thailand.

Symptoms of AIDS

The respondents were asked what they thought the possible symptoms of AIDS could be in a multiple-choice questionnaire (Table 3.33). A very significantly high proportion of "unsure" answers again indicated a great degree of confusion about the disease. About half of them knew about two common symptoms of AIDS, i.e. loss of weight and skin infections but only a few knew about chronic diarrhoea or cough. The mean of the scores of these answers were analysed against the demographic and migration variables by one-way ANOVA. Respondents who are less than 30 years old have more correct answers than older people (over 40 years). There is no gender difference but single people had slightly better knowledge than the married respondents did. No significant difference among ethnic groups was found. Christians have a better knowledge than Buddhists. The level of education played a significant role in their level of knowledge of symptoms. Respondents with more than nine years of education have scored much better than those with no education. Similarly, people who speak little or moderate Thai have a significantly better knowledge than those who do not speak Thai at all do. There is no significant difference among various occupational groups or income groups. A detailed analysis shows that people with more than 4000 Baht monthly income had a slightly better knowledge than those with less than 500 Baht income.

Table 3.33: Knowledge of Symptoms of HIV/AIDS

Symptoms	Yes	No	Don't know	Total
Looks thin, loose weight	53.7	3.7	42.7	100.0
Skin infections	50.3	3.4	46.3	100.0
Fungal infection in the mouth	29.0	1.2	69.8	100.0
Chronic diarrhoea	27.1	3.7	69.2	100.0
Chronic cough	30.9	3.1	66.1	100.0
Chronic fever	36.0	3.1	50.9	100.0

Knowledge of Methods of HIV Testing

The questions about testing methods which require a relatively high level of knowledge have been used to gauge the depth of their general knowledge of HIV/AIDS. Almost half, 47.1% answered the question correctly that blood testing is the right method for HIV diagnosis, and only 3.4% gave the wrong answer (Table 3.34). However, 49.5% of the respondents are "unsure" whether blood tests are used for HIV testing. This is simply a reflection of general

ignorance about the disease and its prevention. When asked if urine tests could diagnose HIV, 26.2% of respondents agree and another 62.2% are "unsure" about it.

Table 3.34: Knowledge of Tests for HIV Diagnosis

Testing Methods	Yes	No	Don't know	Total
Blood test	47.1	3.4	49.5	100.0
Urine test	26.2	11.7	62.2	100.0

Cure for HIV/AIDS

The respondents were asked if there is a cure for AIDS, and 45.2% replied "yes" and 6.8% "no", while yet another 48% do not know the right answer (Figure 3.14). There appears to be a constant problem of misunderstanding about AIDS treatment. While the media and some AIDS workers continue to place high hopes on the "cocktail therapy", many other local and indigenous groups emphasise the "exciting" value of some herbal and traditional therapies. These different approaches have created a mixed situation of hopes and desperation in the mind of people especially those infected or suffering from AIDS.

Figure 3.14: Kowledge of Cure for AIDS by Education

There is a significant difference among various age groups, gender or marital status concerning knowledge. Figure 3.14 also shows that those with more than nine years of education have a better knowledge, i.e. 68.8% disagree that there is a cure for AIDS compared to only 30.8% of those with no formal education. Similarly people with higher education (more than nine years) are less uncertain, i.e. 31.3% do not know about an AIDS cure compared to a high proportion of 65.4% with no formal education. No significant difference is found among various ethnic groups. However, 66.7% of the Christians and 70.0% of the Muslims said that there is no cure for AIDS compared to 41.4% of the

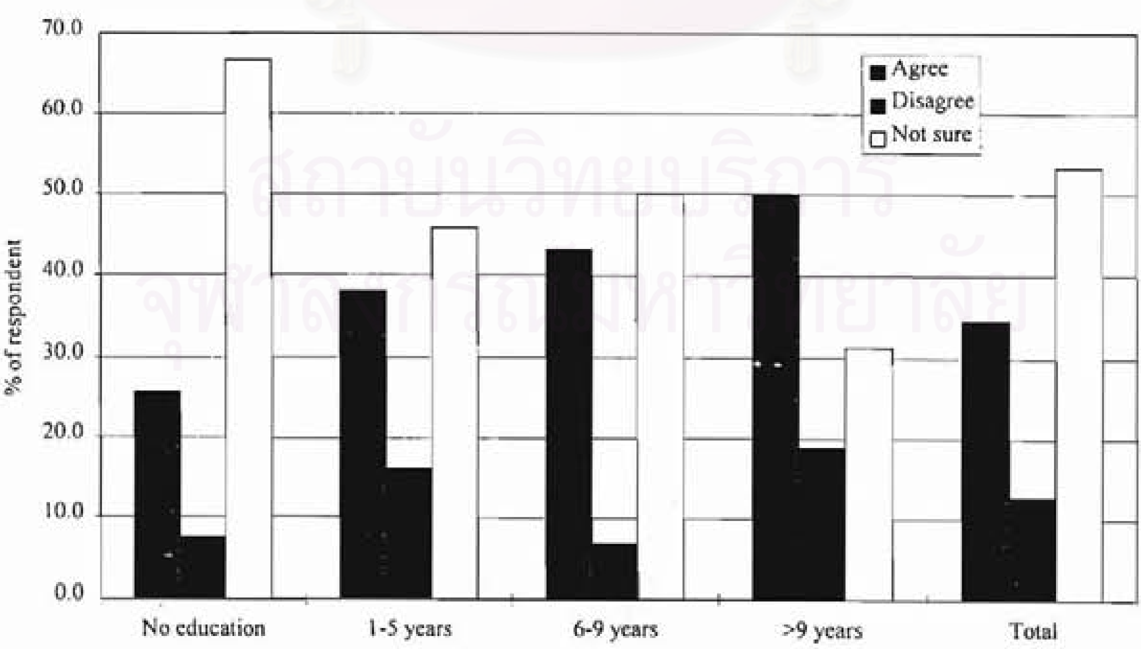
Buddhists. Similarly, a high proportion of Buddhists (53.4%) are not sure if there is a cure for AIDS compared to a lower percentage of Christians (19%) and Muslims (20%). The duration of stay in Thailand or the living situations do not significantly influence the level of knowledge. Traders have the highest proportion of correct answers compared to the agriculture sector, fisheries and construction workers. This difference is attributable to their higher education and better access to information. Similarly, people with a higher income have a better knowledge as most of them belong to trader or other higher education groups.

In summary, overall the general knowledge about HIV/AIDS has no correlation with age, gender, marital status, ethnicity and the duration of stay in Thailand. There is a significant difference, however, between the two main religious groups with Christians having a better knowledge than Buddhists. There is no significant difference among education sub-groups but respondents who had more than nine years of education scored slightly better than all other groups, especially those without any formal education. Respondents who speak moderate Thai have a significantly better knowledge of HIV/AIDS than those who do not speak Thai at all. There is no significant difference among various occupational and income groups, but it appears that the service, maid and factory workers have a slightly better knowledge than the fishermen and agriculture workers.

Prevention of HIV/AIDS

Respondents were asked if condoms can prevent the sexual transmission of HIV. Only 34.6% of them have agreed, 11.9% disagreed but more than half, 53.5% are not sure or do not know (Figure 3.15). It is possible that at least some of them have no idea about condoms. Those with a higher education have a significantly better knowledge about condoms with 31.3% who have more than nine years of education compared to 66.7% of those with no formal education that were "not sure" about HIV prevention through condom use. Similarly,

Figure 3.15: Knowledge of Prevention of HIV by Use of Condom



50.0% of those with more than nine years of education have agreed that condom use can reduce the transmission of HIV compared to only 25.7% of those with no formal education. Similar to the level of education, those with better Thai language ability proved to have a better knowledge about the usage of condoms (Table 3.35). The majority, 67.7% of those who do not speak Thai are not sure about the usage of condoms compared to only 23.1% who speak good Thai. Those with good Thai literacy also have a high proportion of correct answers, i.e. 53.8% agreed to the prevention of HIV through condoms compared to only 25% of those who do not write Thai. There are several reasons for these uncertainties. Firstly, people with no Thai language ability are not receiving the Thai media messages because they do not understand the language and remain confined to their work and within their close communities. These people also have a lower level of education. Those who understand and speak Thai have a generally better exposure to Thai society and are getting the right messages from knowledgeable people outside of their own communities. It has been mentioned earlier that most of the people still receive their information about HIV/AIDS from other people and not from the mass media or organised HIV/AIDS awareness campaigns.

Table 3.35: HIV Prevention by Condom Use by Thai Language Proficiency

	Don't speak	Little	Moderate	Good	Total
Agree	25.0	38.0	39.3	53.8	34.6
Disagree	7.3	9.1	23.2	23.1	11.9
Not sure	67.7	52.9	37.5	23.1	53.5

There is no significant difference among various age groups in knowledge about condom use. Overall, men have a significantly better knowledge about condom usage than women do. An overall 40.0% of men agree that condom use could prevent AIDS compared to only 26% of the female respondents. This is not surprising taking into account that in many communities women have less knowledge about many sexual and health related issues. A slightly higher proportion of single people have a better knowledge (45.1% agree) about condom use compared to their married counterparts (30.6%). This might due to the fact that married people are less likely to get involved in "casual sex" than the singles among whom condom use is more common. There is no significant difference among the different ethnic groups. Christians have a slightly better knowledge (57.1% agree) than Buddhists (31.1% agree) and Muslims (40.0% agree). Among various occupational groups, people in the agriculture sector have more "not sure" answers (59.3%) than traders (37.5%). There is no significant difference among other occupational groups as well as income groups or the duration of stay in Thailand.

Misperceptions of HIV/AIDS Prevention

There are plenty of misperceptions that affect people's decision to take preventive measures for HIV transmission. Some of these misperceptions may directly or indirectly increase their HIV vulnerability. Respondents were asked questions about some of the common misperceptions about HIV/AIDS prevention (Table 3.36). Once again, a very large number of "unsure" answers show uncertainties in the minds of people. There are significant problems with the "misperception" that having sex with healthy partners could actually prevent HIV infection. Sex workers often base their decision whether to use condoms or not

on the healthy appearance of their clients. Many sex workers also believe that getting tested for HIV every three months will keep them safe from a possible HIV infection. It is a well-known fact almost everywhere apart from Japan that condom use in a regular relationship is not accepted as a norm and worse yet fraught with suspicion. As a result, condom use remains very low among regular partners despite the fact that many of them are actively involved in risk behaviours for HIV transmission. Many fishermen and other clients of sex workers have the dangerous "misperception" that drinking alcohol before having sex with the sex workers will safeguard them from HIV infection. So instead of using condoms they drink heavily before visiting the sex workers and persuade them not to bother about using condoms. In some instances they are simply too drunk and would not accept any suggestions from the women why they should use it.

Table 3.36: Misperceptions of HIV/AIDS Prevention

Prevention Modes	Agree	Disagree	Don't know	Total
Having sex with healthy partners	12.5	31.7	55.8	100.0
Not use condom if partner is not a CSW	20.2	24.5	55.4	100.0
Not inject semen/sperm inside vagina	19.5	20.4	60.1	100.0
Drink alcohol before and after sex	8.8	39.9	51.2	100.0
HIV testing every three months	28.4	18.6	53.0	100.0

The mean scores of the answers in Table 3.36 are analysed against demographic and migration variables by one-way ANOVA. These analyses show that there are no significant differences about these misperceptions among various age groups, gender or marital status. All ethnic groups have almost the same understanding about these misperceptions with Mon having slightly more misperceptions than Karen. Buddhists have significantly more incorrect answers compared to their Christian and Muslim counterparts. People with no formal education have significantly more misperceptions than those with more than nine years of formal education. No correlation was found with the duration of stay in Thailand. Those with no Thai language ability have significantly more misunderstandings about HIV prevention than those with a very good Thai language ability. There is no significant difference among various occupational or income groups. but detailed analysis reveals that factory workers, service workers, maids, and traders have a slightly better understanding than fishermen and agriculture workers. This analysis also illustrates that the higher income groups have a better knowledge about HIV prevention than the lower income groups.

In summary, knowledge about HIV prevention proves to have no correlation with age, gender, marital status, ethnicity and the duration of stay in Thailand. There is, however, a significant difference between two main religious groups; Christians have a generally better knowledge of prevention than Buddhists. There is also a significant difference between respondents who had more than nine years of education and those without any education. Respondents who speak good Thai have a significantly better knowledge of HIV prevention than those who do not speak Thai. Finally, there is no significant difference among various occupational groups but it appears that the service, maid and factory workers have slightly more knowledge than the fishermen and agriculture workers. This also coincides with the fact that people who earn more than 4000 Baht per month have better knowledge than those

with less than 500 Baht income. The latter income group mostly belonging to the agriculture sector and fisheries.

Summary of HIV/AIDS Knowledge

Finally total knowledge of HIV/AIDS transmission, symptoms, testing, prevention and cure has been analysed against occupation by one way ANOVA (Table 3.37). It indicates that the mean knowledge score of all respondents is 0. 4054 out of possible 1.0000 which is much lower than mean score of 0.5241 of the study population in Ranong. Traders have the highest score in Sangkhlaburi (.4917) followed by service workers and maids, .4905 . Agriculture workers have the lowest score at .3693 which is close to that of the lake fishermen at .3869. These total knowledge scores can assist in prioritising the target population for the intervention programme.

Table 3.37: Total Knowledge of HIV/AIDS by Occupation

Descriptives

			N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
							Lower Bound	Upper Bound		
total kn (g/t/p)	present occupation occ1	agriculture	189	.3693	.2273	1.653E-02	.3367	.4019	.07	.90
		fishery	22	.3869	.2167	4.620E-02	.2908	.4830	.13	.74
		trader	8	.4917	.1891	6.685E-02	.3336	.6497	.26	.73
		construction	22	.4106	.2047	4.364E-02	.3198	.5014	.13	.78
		factory	19	.5074	.1839	4.219E-02	.4188	.5961	.13	.74
		service/maid	31	.4905	.2020	3.628E-02	.4164	.5646	.13	.94
		temporary labor	35	.4588	.2033	3.436E-02	.3889	.5286	.11	.79
		Total	326	.4054	.2212	1.225E-02	.3813	.4295	.07	.94

3.8 ATTITUDES AND BELIEFS ON SEXUAL BEHAVIOURS

Sexual behaviour and acceptable norms

Culturally and socially acceptable sexual behaviour may vary from country to country and even within the sub-populations in a country. For example, many of the hill-tribe and ethnic minority populations in northern Thailand have a much more open attitude towards commercial and extramarital sex than those from the southern part of Thailand.

Respondents were asked the following questions concerning sexual behaviour and their acceptance in the community (Table 3.38). It reveals some predictable results as more men approve of pre-marital sexual relations including commercial sex. Very few men and women approve of extra-marital sex. Exactly 24.1% of men agree that single men can have sex with women who are not commercial sex workers compared to only 9.1% of women. Similarly, 42.4% of the male respondents approve single men having sex with sex workers compared to 17.6% of the women. Looking at the opposite, 24% of men approve women to have sexual relations with men and 10.3% of the women. These findings show the crucial gender differences in sexual behaviour of the study population, which is probably very common in many other countries in the region. It is partly because of these socially acceptable norms that the mobile population avails themselves of opportunities to develop sexual relationships in their adopted homes, or worse yet in terms of HIV transmission they visit commercial sex venues. Migrant women may willingly or unwillingly become part of this sexual network and perhaps as sex workers.

Table 3.38: Sexual Behaviour and Acceptable Norms

Sexual Practices	Agree			Disagree			No opinion		
	M	F	Tot	M	F	Tot	M	F	Tot
Married man could visit commercial sex workers	4.0	2.4	3.4	91.5	93.7	92.3	4.5	3.9	4.3
Married man could have sex with other women (not a CSW)	7.5	4.7	6.4	85.9	88.2	86.8	6.5	7.1	6.7
Single man could visit commercial sex workers*	24.1	9.1	18.4	64.8	78.0	69.9	11.1	12.6	11.7
Single man could have sex with other women (not a CSW)*	42.4	17.6	32.8	49.0	68.0	56.3	8.6	14.4	10.8
Married woman could have sex with other man (not husband)	2.5	1.6	2.1	95.0	93.7	94.5	2.5	4.7	3.4
Single woman could have sex with other man*	24.6	10.3	19.1	70.4	84.9	76.0	5.0	4.8	4.9

** statistically significant difference between men and women;*

The above findings are consistent among various ethnic and religious groups, and levels of education. The findings also do not differ much due to the marital status of the respondents. Among various occupational groups, only the fishermen have a very high approval rate for

single women to have sex with other men (40.9%) compared to about 20% or less for all other occupational groups.

Masculine Behaviour and Acceptability

Many traditions and cultures have their brand of masculine prowess and some of them could actually be harmful "misconceptions" leading to risk behaviour for HIV transmission. The following questions were asked concerning masculine behaviour (Table 3.39) and their acceptability by the study population.

"*Khuen khru*" or getting first sexual experience with a "professional" woman before marriage has long been a common practice in Thailand and some other countries in the region. Usually an eligible young Thai man would go to a sexually experienced women for his first sexual lessons often before he gets married. Most of these 'experienced women' are sex workers nowadays and widely known in the particular community. In recent years, however, the significance of this traditional practice has lost its importance because of social transformation and also fear of AIDS transmission. It is not clear if this has ever been a common practice in Myanmar. Over two-thirds (67.8%) of the respondents disapprove of this practice and only 12.3% agree with it. There were three questions about condom use. A slight majority of 53.3% of respondents disagreed that the "man who does not use condoms during sex is brave". This represents a good general attitude. A proportion of 23.9% agree that condoms reduce sexual feelings and gratification and 67.1% are unsure about it. It is quite possible that many of those in the "unsure" group have not had any experience with condoms as its overall use among the population is very low. The last question asked about condom use suggests disregard or not being faithful to their partner which is a common problem in many cultures, and even in spite of an extensive HIV/AIDS campaign this attitude has not changed much. In fact, this is one of the main reasons why a large number of

Table 3.39: Masculine Behaviour and Acceptability

Masculine Practices	Agree	Disagree	Don't know	Total
Single man should have "kruen krue" (get sexual experience) before marriage	12.3	67.8	19.9	100.0
Man who do not use condom during sex are brave	12.3	67.8	19.9	100.0
Drinking alcohol before and after sex prevents HIV infection	8.3	53.2	38.5	100.0
Using condom during sex reduces sexual feelings and gratification	23.9	9.0	67.1	100.0
Using condom shows disregard about your partner (being not faithful)	25.2	16.0	58.8	100.0
"Fung Muk" or injecting oil or substance to enlarge penis satisfy women	22.2	28.0	49.8	100.0

women are becoming infected by their male partners who contract the disease through 'unsafe' commercial or casual partner sex. "*Fung muk*" refers to the implantation of marble or some other hard materials under the skin of the penis. This is a popular practice among

some population groups, e.g. fishermen. As much as 22.2% agreed that "*Fung muk*" increases sexual gratification, and in fact, during interviews at least five of the respondents claimed to have it in themselves. There is a significant gender difference in the acceptability of all of these masculine behaviours with women generally disapproving of them. There was no significant difference among ethnic, religious or occupational groups about these practices.

3.9 ATTITUDES TO PEOPLE LIVING WITH HIV/AIDS (PWHAs)

Attitudes towards PWHAs are a critical issue in many countries as families, friends and communities struggle to come to terms with the "unexpected event" in their lives. In many places, the PWHAs and their families are very isolated, discriminated and abused. The answers from the respondents on these issues are very much predictable (Table 3.40). Most of the respondents categorise HIV/AIDS as a serious communicable disease which can be transmitted by casual contacts such as touching, shaking hands, sharing toilets and bathrooms, sharing the office or house, sharing bed or clothes etc. (see misperception of transmission). In reply to the proposition "if you have an HIV/AIDS positive person in the family, will you let him/her live in the same house with you", 95.1% of the respondents disagreed to do so and only a handful of 3.4% agreed. In another question, 74.7% of the respondents disagreed to be willing to live and work with HIV-positive people. Similarly, 76.2% of the respondents disagreed that "HIV/AIDS positive people should not be isolated and stay with normal people". More than half or 57.3% of the respondents disagreed to visit an HIV-positive friend.

As indicated earlier, these attitudes towards PWHAs are all too familiar. Means of the scores from all answers are analysed for a correlation by the demographic and migratory experience with the one-way ANOVA method. It shows that there is no significant difference among various age and ethnic groups. Women have more negative attitudes than men. Among religious groups, Buddhists have more negative attitudes than Christians and Muslims.

Table 3.40: Attitude Towards PWHAs

Situations and Statements	Agree	Disagree	Don't know	Total
Should not hate or be afraid of AIDS patients as it is not easily transmitted	27.6	63.7	8.7	100.0
Should have compassion and sympathy for HIV/AIDS positive people	47.1	47.4	5.6	100.0
Could live and work closely with HIV/AIDS positive people	18.8	74.7	6.5	100.0
If you have a HIV positive friend, you will go to visit him/her	35.5	57.3	7.2	100.0
HIV/AIDS positive people should not be isolated and stay with normal people	17.3	76.2	6.5	100.0
If you have a HIV/AIDS positive person in your family, you will let him/her live in the same house with you	3.4	95.1	1.5	100.0

There is no significant difference among educational groups but those with more than nine years of education have a better attitude than those with no education. People who speak good Thai have a significantly better attitude than those who do not speak Thai. There is no significant correlation with the duration of stay in Thailand. There is also no significant difference among various occupational groups, but differences exist, however, between higher income (>4000 Baht) and lower income (<500 Baht) groups. These findings are consistent with the overall knowledge about and the prevention of HIV/AIDS as described earlier.

3.10 RISK SITUATIONS AND RISK BEHAVIOURS FOR HIV/AIDS

In this section we look into the specific risk behaviours of the respondents as well as surrounding risk situations that influence their vulnerability to HIV/AIDS. This includes their sex behaviours and sexual networking in the community including access to commercial sex. It also discusses IDUs which is directly linked with HIV transmission. While alcohol and non-injectable drugs may not pose a direct threat for HIV transmission, they however have serious implications on people's social and sexual behaviours and therefore are included in this section. Some of the masculine behaviours, such as *fung muk*, which may have an important bearing on HIV/STDs transmission are also covered here.

The risk situation analysis has been done by interviewing the respondents about their habits of alcohol consumption, drug use, needle sharing, history of blood transfusions, sex behaviours in regular, casual and commercial sex, and condom use in each these circumstances. Additional qualitative analysis was done by key informant interviews, field observations and a contextual analysis of the overall situation.

Regular and Casual Partner Sex

A great majority of HIV transmission occurs by heterosexual intercourse. In most circumstances the 'first wave' of infection spread through commercial sex. Sex workers get infected from their clients and in turn other male clients get infected who then transmit it to their wives, girlfriends and other partners. It is important to identify this locus of infection at the early stage of the epidemic if possible. But as the number of HIV positive people increases in a society, it is much more important to determine the sexual networking outside commercial sex too. Because in such circumstances casual and multiple partner sex could become an important source of HIV transmission. So in determining HIV vulnerability of a particular population, it is quite essential that we look into total sexual network i.e. regular partner, casual partner and commercial sex.

Table 3.41 shows various forms of sexual encounters of the respondents in the last one year. As one would normally expect married people have a high rate of regular partner sex. Regular partner here implies to married couple, common law spouse, minor wives and boyfriend-girlfriends i.e. the couple who have some sort of commitment towards each other and have social acceptance as sex partner. Interestingly, among married people there are significant numbers who have casual sex (24%) and they are equally distributed among men and women. That means both men and women engage in casual sex while they continue their

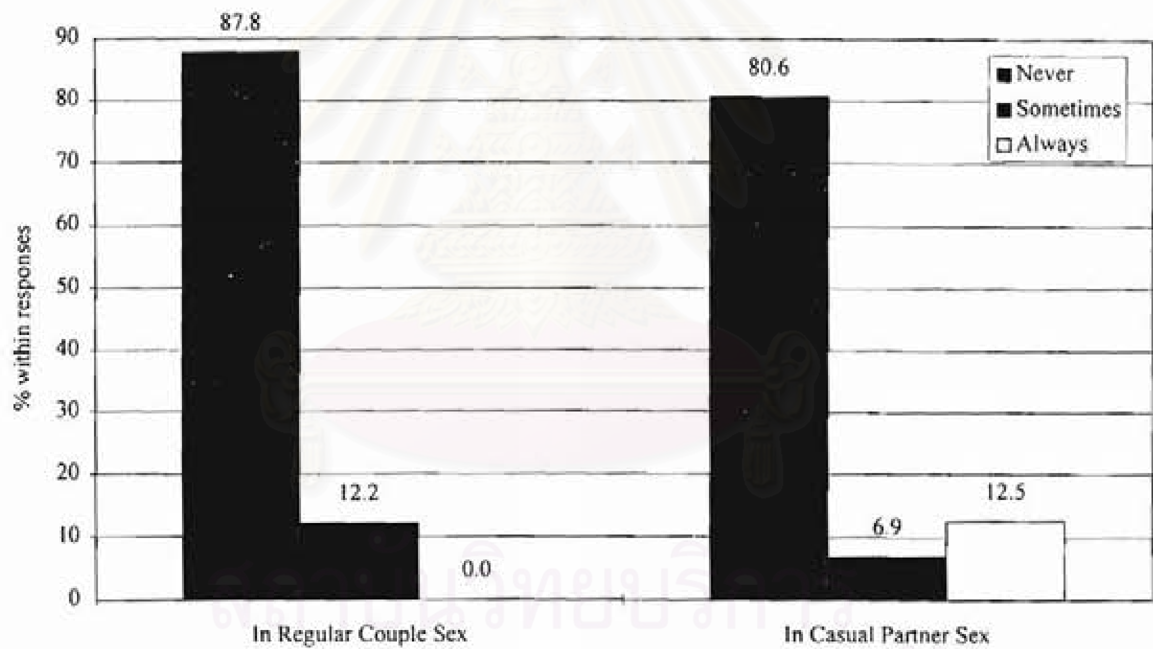
Table 3.41: Sexual Networking by Marital Status

	Single No(%)	Married No(%)	Divorced/Widow No(%)	Total No(%)
Regular partner	4(4.6)	161(73.2)	6(54.5)	171(53.8)
Casual partner	14(16.1)	53(24.1)	5(45.5)	72(22.6)
No sex partner	69(79.3)	6(2.7)	0(0.0)	75(23.6)

regular partner sex with their spouse. Of the small number of divorcees and widows, ten of whom are women all have sexual partners either casual or regular partner. This is an important finding for the HIV/AIDS programme as they often ignore this particular group or population in interventions. Most of the single men didn't have any sex partner (79.3%) and some of them have casual partner. Only a few single women have any kind of sex partner.

A total of 72 (22.6%) respondents admitted to having sex outside their wedlock or regular partnership of whom nine (12.5%) used condoms all the time, five (6.9%) sometimes and 58 (80.6%) never. In regular partner sex nobody uses condom regularly and 12.2% say sometimes. When asked about the purpose of condom use they are vague about it, some say it is for contraception while others thought it helps prevention of some diseases. More investigation may be useful on this issue. On the issue of commercial sex, only four male respondents have visited sex workers in the last year. Others say that sex workers are not easily available in Sangkhlaburi and they are very expensive. They, however, reported that some men go to work in other places in Kanchanaburi and visit sex workers there.

Figure 3.16: Condom Use in Regular Couple and Casual Sex



Commercial Sex:

Unlike many other cross-border locations, there is a diminutive sex industry in Sangkhlaburi. There is no red or pink light district in this small town. All entertainment venues are in Chedi Sam Ong on the Thai side of the border. One 'restaurant' has a number of girls and a few rooms for rent in the backyard. So services are available in the venue. This is popular among traders and truckers. A karaoke bar is another popular place. Here girls are available in and outside the bar to be picked up by their clients. This place is popular among local officials and wealthy residents. A 'traditional' massage parlour is an easy way to find girls and commonly used by the tourists and visitors but also local officials. So all in all, there are about 20-25 sex workers in Chedi Sam Ong and most of them provide 'indirect' sex services.

Only Burmese girls work in the restaurant and karaoke bar whereas both Thai and Burmese girls work in the traditional massage. Some of the girls live in Chedi Sam Ong, while others live in Phyathongsu and commute daily to their work.

Most of the Burmese sex workers in Sangkhlaburi have come from Hton-Ain and Kya-Ain-Seik-Kyi of Karen State, Moulmein of Mon State, and some of them as far as Yangon. In most instances, the girls make a 'voluntary' decision to work as a sex worker before leaving their village. Others make up their mind or are persuaded to do so while they are in the border. Occasionally, some girls are forced or coerced by unscrupulous agents to work in the sex industry. This is significant departure from the past when most of the girls were reportedly trafficked and forced to work in the sex industry and often in the brothels (Asia Watch 1993). At present these 'voluntary' sex workers prefer to work in places that are far away from their villages for they try to avoid being recognised by their known people. This helps them to escape social stigma associated with prostitution in their society.

Like in many other similar situations, economic hardship in Myanmar has been cited as the main reason for working in the sex industry. The girls complain about a lack of job opportunities and a descent income to lead a normal life. As a result of the above, some young girls and women leave their villages to work in Thailand. Some of them have already returned home with their goods and money and boast about their success and show off with their jewellery and fancy clothes. This encourages other girls and women to leave their villages without being fully aware of the dangers posed to them.

There has not been much growth in Sangkhlaburi sex industry in the last several years. Poor demand has been cited as a reason for this. Local Thai people and migrant workers usually live with their families and in fact, cannot afford the high cost of sex services. Therefore most of the clients of the sex workers are Thai military and border police, government officials, and wealthy local residents. Because it is a remote district, some of these officials do not have their family with them. So they usually gather for an evening's entertainment of drinking and socialising with friends and women in the venues. Some of these relationships end up in sexual encounters. Some men have their 'special women' and they become partners for some time. Tourists and visitors also form a segment of the client base. There are also some Burmese girls who live in the community and can be contacted through motorcycle drivers, restaurant waiters, or guest-house boys. These girls remain very discreet and provide services in the guest-houses or private homes and not in the girls' house.

Most of the sex workers rotate for about two months on average. Some of them move deeper inside Thailand for a better income. Thong Pha Phum district in Kanchanaburi is one of the popular destinations for the sex workers. Some of them also go to Pah-Kant in the Mon state that has a large jade mine. Condom use is irregular which depends on many factors ranging from the girl's knowledge, availability of condom, willingness to use by the client etc. Of four men who admitted visiting sex workers one never used condoms and the other three say that they occasionally used. There is no organised system of condom promotion and distribution in the area as the sex workers are very discreet and are not so easily accessible. They also do not have an organised system of the diagnosis and treatment of STDs but depend on a private drug store in the market. Usually they plan to work for a short period of time to earn money, and then work in their familiar occupations such as tailoring, and small scale trading. It is not, however, clear if and when their 'dream' will come true.

Drugs, Substance and Alcohol Use

Eleven respondents (3.4%) - eight men and three women - have reported **injecting drug use (IDU)** and six of them - five men and one women - admitted to sharing needles. IDUs are a serious problem among certain population groups in Myanmar and Thailand, two countries that are part of the so-called opium producing "golden triangle" area. The areas adjacent to Sangkhlaburi are not so well known for drug trafficking and IDUs, but the area has never been seriously investigated for it either. The above finding of 3.4% respondents using injecting drug is significant and deserve careful assessment and programming in the area. It is known that HIV prevalence among IDUs in Thailand remains static at over 40% and the same may be true for the migrant population in Sangkhlaburi too.

Marijuana is sometimes used by 15 respondents (4.6%), all of them men. They claimed not to have taken it regularly and some of them have already stopped its use. Nine respondents reported the usage of **methamphetamines pills**, another common drug used in Thailand and many of its neighbouring countries. Amphetamines are one of the rapidly growing drug addictions that affect youngsters and many other population groups. Because of apparent stronger control measures in Thailand, many of the drug production rackets have moved into Myanmar and other neighbouring countries resulting in a wider use in those places. While these drugs do not have any direct bearing on the HIV transmission, they however affect people's psyche and sexual behaviours.

Alcohol consumption is reported by a total of 134 (41%) respondents of which 5.8% drink alcohol regularly, 26.0% sometimes and another 9.1% claimed to have stopped drinking altogether. There is a significant gender difference as only 7.1% of the women drink alcohol compared to 62.5% of the men. None of the women drink alcohol regularly. Older people drink alcohol more regularly while the younger people consume alcohol only sometimes. There are strong links between heavy drinking and casual sex in the migrant's communities.

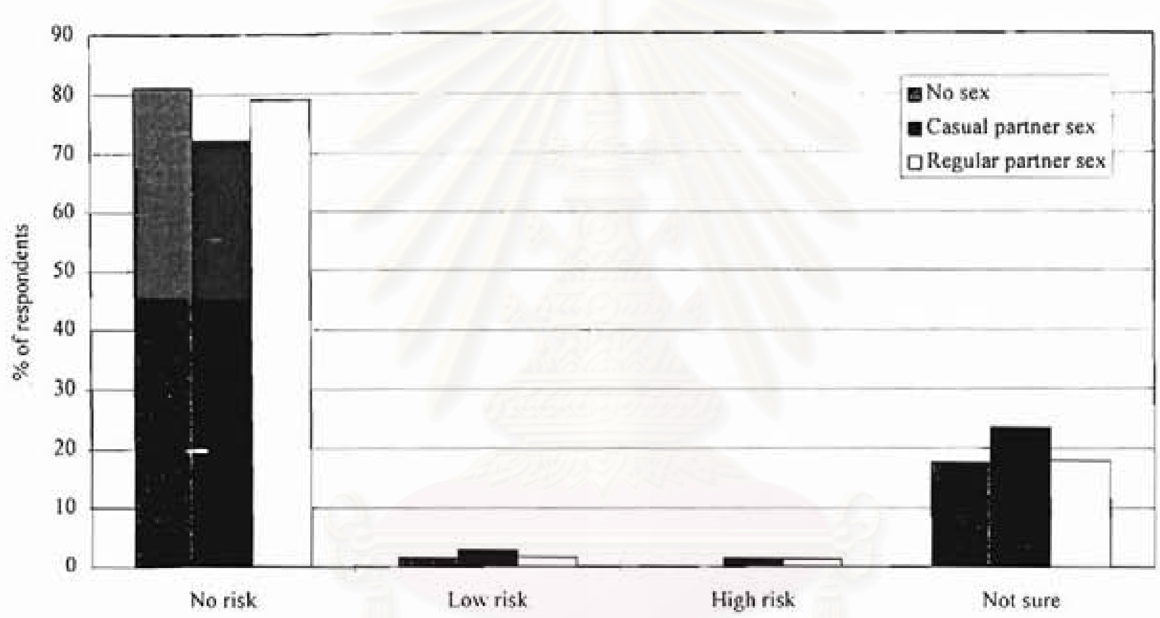
Sangkhlaburi and its bordering areas inside Myanmar are known for its notorious drug resistant falciparum malaria. Many of these malaria victims become anaemic and often require blood transfusions. Fifteen respondents received **blood transfusions** - seven in a Thai hospital, one in a Thai private hospital, five in a Burmese hospital and one in a Burmese clinic. HIV screening of blood is available in both district and Christian hospitals in Sangkhlaburi and some have detected HIV positive donors but data is not available for the writing of this report. Emergency blood transfusion is done in Phyathongsu hospital without screening for HIV which is not available at this remote district, a serious issue that deserves careful attention from the Myanmar government and donor communities.

Self-Assessment of HIV Vulnerability

Towards the end of an about twenty minute interview, the respondents were asked to make a self-assessment of their own HIV vulnerability by taking into consideration all knowledge, attitude, belief and practice about the disease. They are given the option to choose a single answer from "no risk", "low risk", "high risk" or "don't know". A great majority of the respondents or 78.5% have answered no risk, 18.8% don't know and only a few said low or high risk. Most of them have great difficulty is assessing their own vulnerability. They can

however assess the vulnerability of someone else if given a hypothetical scenario. It is quite possible that these answers are at least in part influenced by their own attitude towards PWHAs which means that many people simply cannot imagine themselves to be one of those unfortunate people. Interestingly the same question was asked to the people who had 'unsafe' casual sex, those who had regular partner sex and then compared these with people who had no sex, the answers were quite similar (see Figure 3.17). Almost nobody thinks they are at risk but about one fifth of them are not sure about their vulnerability. There is no significant difference among various age, gender, marital status, religious, ethnic groups, length of stay, education, Thai language ability, occupation or income groups. This illustrates that the "misperceptions of HIV vulnerability" cut across all walks of life of all people.

Figure 3.17: Self-assessment of HIV vulnerability by Sex Behaviour



Multivariate Analysis

Multiple regression was undertaken for further clarification of the study findings. The variables pertaining to HIV/AIDS knowledge are analysed by linear regression and those pertaining to HIV risk behaviour through logistic regression.

1. HIV/AIDS Knowledge

Knowledge as the dependent variable, includes general knowledge of HIV/AIDS as well as on transmission, symptoms, testing, prevention and cure as discussed in the section 3.7, all of which are combined to form overall knowledge for this analysis. The predictors are selected from 20 demographic and migration variables which are all tested against knowledge as the dependent variable. Demographic variables are: age, gender, education, ethnicity, religion, marital status and occupation. Migration variables are: hometown or place of origin, previous occupation, encouragement for migration, prior information about Thailand before migration, contacts with hometown, income, savings, sending remittances,

length of stay, place of living, living with whom,, community participation, rest and recreation activities and Thai language proficiency. Aother variable used is self-assessment for risk of contracting HIV.

Table 4.42 describes significant variables that have correlation with the dependent variable knowledge. They are five significant variables and all of them have positive correlation with knowledge. Respondents with higher education, religion Christian, occupation factory workers, place of origin Yangon and single accommodation have higher knowledge.

Table 3. 42: Multiple Regression Demographic and Migration Variables on Knowledge of HIV/AIDS

Predictors	β	t	Sig
1. Higher education	.273	3.385	.00
2. Religion-Christian	.273	3.383	.00
3. Occupation -factory worker	.273	3.008	.00
4. Place of origin Yangon	.198	2.625	.01
5. Accommodation's condition Stay alone	.197	2.022	.05

R = .58 F = 3.314 Sig = .00

2. HIV/AIDS Risk Behaviour

Risk behaviours, defined here as casual partner sex and visiting CSW is the dependent variable. The predictors are selected from the demographic and migration variables, as described above, plus attitudes on two areas, namely: attitudes towards PWHAs and attitudes towards social (sexual) norms as well as overall knowledge score and self assessment of risk. Logistic regression is used for the analysis.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Table 3.43: Multiple Regression Analysis of Risk Behaviour: Casual Partner Sex

Predictor	B	S.E	R	Sig
1. Income - higher	-2.1166	1.0305	-.0840	.00
2. Accommodation's condition – stay with same sex friends	.0003	.0001	.1600	.00

In Table 4.43, there are two variables showing significant correlation, one is negative, namely high income is associated with casual partner sex. The second is a positive correlation, that is, those living with same sex friends, mostly all male households have high probability for having casual partner sex.

Summary and Discussion of HIV/AIDS Risk Situation

In summary, the migrant population in Sangkhlaburi have very low knowledge of HIV transmission, symptoms and cure. They have many of misperceptions of the disease and many people are simply not sure what it is about. Most of them have heard about HIV/AIDS and STDs by talking to someone else and only a minority through any reliable methods such as television, posters, health staff or NGO workers. It is evident from this study that the messages they receive by talking to people are often not correct or lack details.

High risk behaviours for HIV transmission among this population do exist in many respects. Like any other society, the people continue to have unprotected sex outside their usual couple. This is especially common among people living in groups and without nuclear family. Divorcees and widows seem to be particularly vulnerable to unprotected if not multiple sex partners. Although commercial sex industry is not so active in the area, they do exist and are availed by certain groups of people mostly Thai. There are also men and women travelling to other parts of Thailand and at least some of them are exposed to the unprotected sex and injecting drugs. They mix among the people in Sangkhlaburi and adjacent areas. From the limited available data, it may be said that STDs do exist among migrant population in Sangkhlaburi that make them more vulnerable to HIV infection. However, more investigation is needed in this area.

Drug and substance use is prevalent in the area like many other parts of Thai-Myanmar border. Eleven reported cases of IDUs could in fact lead to a larger groups of drug users. Considering high HIV prevalence of HIV among IDUs, it strongly suggested to do more thorough analysis of the situation and develop appropriate intervention programmes.

Given all the facts in the above section, it can be concluded beyond doubt that much of the migrant population in Sangkhlaburi area and adjacent refugee camps on the border are vulnerable to HIV transmission. Despite the relatively lower frequencies of high risk behaviour, they are handicapped by poor knowledge and preventive practices to protect themselves from the disease.

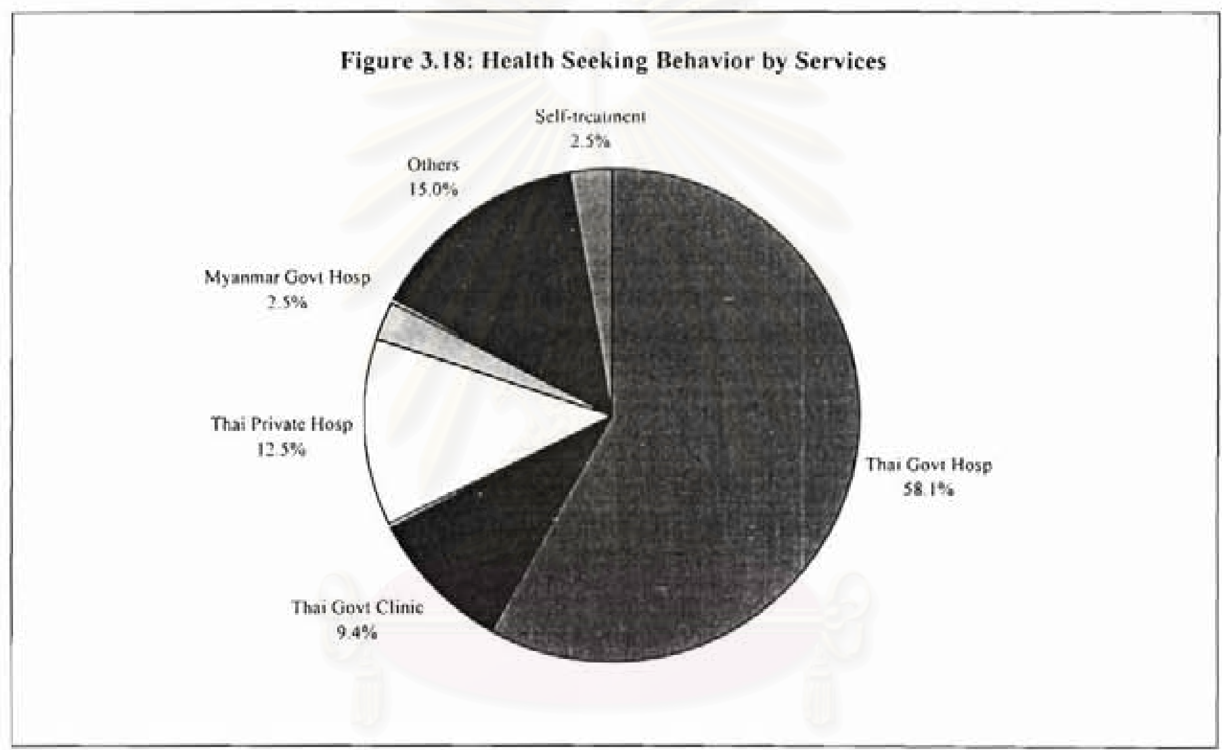
สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

3.11 HEALTH SEEKING BEHAVIOUR AND HIV/AIDS SERVICES

A very large number or 87.7% of the respondents know about health services in Thailand. Mon have slightly better knowledge about it than other ethnic groups. This is related to the longer length of stay in Thailand which shows that only 69% of the respondents who stayed less than one year know about health services. Mon also have friends and relatives in the area who migrated earlier and helped them get acquainted with the services.

When asked where they would usually go for treatment if they became ill, a majority 58.1% preferred the Sangkhlaburi district (government) hospital followed by 12.5% who preferred the Christian Missionary Hospital (CMH) in the area.

Figure 3.18: Health Seeking Behavior by Services



Married people are more likely (81.5%) to visit the district hospital compared to 62.2% of single people. No significant difference was found among various age groups and gender. More Christians (40.5%) prefer to visit the CMH compared to 8.0% of the Buddhists who like to go to the district hospital. Among ethnic groups, Karen -many of whom are Christian - have a slightly higher preference (21.7%) for the CMH compared to 7.2% of the Mon and 10.0% of the Burmese. The latter two ethnic groups prefer Thai hospitals. Among occupational groups, factory workers are more likely to go to the CMH. People with no formal education are less likely to go to the Missionary Hospital. Those who speak better Thai, are more likely to go to the Thai hospital. One surprising finding of the study is the fact that the respondents show little preference for traditional healing practices which was thought to be common among many rural folks and minority groups in Myanmar and elsewhere in the region.

Table 3.44: Visit to the Thai hospital by Ethnicity

	Burmese	Mon	Karen	Others	Total
Male	67.7	79.8	69.2	72.7	74.0
Female	60.0	87.8	79.2	60.0	78.7
Total	64.7	82.6	73.7	68.8	75.9

The majority of 76.1% of the respondents have already visited the Thai hospital. Among ethnic groups, a slightly higher proportion of the Mon (82.6%) visited a hospital compared to 64.7% of the Burmese and 73.7% of the Karen (Table 3.44) which is similar to other findings that the ethnic minorities have better relation with the Thai people and services. Slightly more ethnic minority women have Thai hospital than their male counterparts respectively. Among occupational groups, 100% of the lake fishermen visited Thai hospital compared to as low as 42.1% of the factory workers (Table 3.45). Almost all fishermen are Mon who have very good relation with the Thai community but most of the factory workers are young Burmese men or women who either do not get sick often or do not like to visit hospital. A varying proportion of the other occupational groups have also visited Thai hospital. The situation is significantly different from Ranong where much smaller proportion of migrants visit Thai hospital.

Table 3.45: Visit to the Thai hospital by Occupation

	Agri	Fishery	Trade	Constr	Factory	Service	Labour
Male	71.8	100.0	83.3	63.2	50.0	84.2	78.6
Female	83.1	100.0	100.0	100.0	40.0	58.3	90.5
Total	75.7	100.0	87.5	68.2	42.1	74.2	85.7

Most of those respondents who stated that they have not visited a Thai hospital were not sick. Similarly, 65.6% of all respondents cited to have had no problem to seek health care in a Thai district hospital. Only 7.1% complained about high cost of treatment and 1.9% cited language barriers. Overall, the respondents expressed satisfaction with the health care in Thai hospitals. At least one child of 42.3% of all respondents and of 58.4% of the married respondents was born in Thailand. The respondents reported six cases of tuberculosis, one leprosy and three mental disorders in their families.

HIV/AIDS/STDs Patients in the Hospital

Patients statistics provided by the hospitals reveal existence of some STDs and HIV-positive people among migrants (see section 3.3). Sangkhlaburi hospital recorded four, three and 14 HIV positive tests among migrants in 1996, 1997 and 1998 respectively. Records are not available if they had more HIV/AIDS patients or not. CMH also recorded 12, 23, 19, 11 and 24 HIV positive people among non-Thai patients i.e. migrants and refugees. In addition, they have cared for six HIV positive people in their rehabilitation centre who were repatriated from the central Thailand. These HIV statistics do not, however, give full assessment that could be comparable to HIV surveillance of pregnant women, blood donors or other sentinel groups. According to the local medic sources, there are more people with suspected

symptoms of HIV/AIDS. Nobody want to do full assessment or HIV testing on them because of lack of proper counselling, confidentiality and more importantly care and support for them. There are many TB patients but they do not check their HIV status. The same sources claim that some of these patients have already died and they died too fast. This is similar to the observations made by the health workers in Ranong and Kawthaung.

A few observations can be made on the health seeking behaviour and services provided by the hospitals and health care system in the area. HIV/AIDS is a relatively new issue for many and especially so for this population who have been detached from their homeland for a long time. They are also somewhat segregated in Thailand because of their illegal status, language barriers and poor economic conditions. Many people do not have access to radio or television and often depends on other people to bring new messages to them. The community structure of the migrants are by and large controlled by the local people, employers and authorities. So they usually do not organise some events like health message or other similar activities by themselves. They continue to depend on the care providers to come up with ideas and initiatives; they may become involved but it depends on their capacity to do so.

All health service providers in the area have only a few HIV/AIDS related activities, mostly limited to some testing and counselling. They are yet to begin any significant HIV/AIDS education campaign either in the Sangkhlaburi district or cross-border locations along the border including the refugee camps. CMH used to have some outreach programme but it is not clear if their activities reache the majority and HIV/AIDS messages and prevention is emphasised in their work. NGOs working with the refugees expressed an interest to initiate an HIV information campaign. It is not clear however when or how they intend to do this. It has been proven time and again that giving HIV knowledge is often not enough for the expected outcome of behaviour change. It is therefore very important that the project staff have a clear understanding of the overall situational context, implementation strategy and monitoring tools to measure the progress of their work.

Nonetheless, the existing health care providers in Sangkhlaburi are in a unique position to take up HIV/AIDS issues in their existing projects. To do so they may require relevant information, experience of HIV/AIDS programming, especially in the cross-border situations, local level discussion and co-ordination, and linking up with national authorities. Most of the agencies also work with tight budget and so far have not allocated much fund for HIV/AIDS activities. So it might also be necessary to mobilise additional financial resources in support of their activities.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

3.12 SUMMARY AND RECOMMENDATIONS

Sangkhlaburi-Phyathongsu is a relatively quiet border crossing between Thailand and Myanmar. The area is covered by deep tropical forest and mountains which are famous for birds and wildlife sanctuaries. The place is also famous for the ancients *Chedi Sam Ong* or Three Pagoda Pass. Because of the difficult terrain and mountain cliffs, there is no well developed transportation infrastructure in the area. Sangkhlaburi has been providing refuge to the Myanmar ethnic minorities mostly Mon and Karen who have been escaping armed conflict with the Burmese dominated regime in Yangon. About 15-20,000 refugees are also housed in several camps in the close vicinity of the border. At present there are about 20,000 migrants in the district that exceeds the number of the local population in the district. Many more migrants who travel to the central Thailand gather at several locations inside Myanmar. As a result, the local economy and social situations are quite mixed with the migrants. Quantitative data was collected by a structured KAP questionnaire from 327 respondents using proportional sampling according to occupation. Additional qualitative data were derived from key informants and two focus group discussions.

Key Study Findings

Migration Situation

1. There are an estimated 20,000 migrant people in Sangkhlaburi district that exceeds the 11,606 local Thai population. Ethnically, most of them are Mon (43%) and Karen (36%) with smaller number of Burmese (16%) (section 3.5). A majority of them originated from the neighbouring Mon and Karen states so the situation here may be termed as a 'migration of ethnic minorities' from Myanmar.

2. Over half (51.5%) of the respondents have lived in Sangkhlaburi for over five years (section 3.6). There are only a few people who are there for short time. Eighty one percent of the migrants live in nuclear or compound families and 42% of the married people have their children born in Thailand. About 65% of respondents do not intend to return to Myanmar and wish to live in Thailand. Many migrants have pink, orange and blue immigration cards allowing their continuing stay in the area (section 3.1), education for their children and access to health care etc. So this is rather a stable migration situation.

3. But there are other migrants who gather at several locations inside Myanmar (e.g. Japanese Well) and travel to central Thailand, do not have the same prospect. They are mostly transitory, enter Thailand illegally and many of them face the prospect of police arrest, punishment and abuse. A large segment of this group are former migrants deported or repatriated by the Thai authorities. Some of them are inhabitants of the refugee camps.

4. About 39% of the respondents are women (section 3.5) who are employed in a wide variety of jobs such as agriculture, service and domestic work, construction, day labouring, factory and commercial sex. In addition there are many housewives who accompany their husbands and families, and do not have any formal job.

5. Agriculture is the dominant industry in this remote rural district that employs up to 58% of the migrant workforce (section 3.5). Another 11% do day labouring, 9.5% work in the service sector including domestic help. Small but a significant 6.7% work as lake fishermen and a smaller number of people work in manufacturing and construction. There are about 20-25 migrant sex workers in the area.

HIV Risk Situations

6. Women have lower socio-economic status in the community because of their low education and skills, job and income opportunities. They also have lower knowledge about HIV/AIDS than men. These combined factors make them vulnerability to HIV/AIDS transmission.

7. Knowledge of HIV/AIDS among the migrant population is very low (mean score = .4054) (section 3.7). People with higher education have higher knowledge. Christians have better knowledge than Buddhists. Factory workers have higher knowledge, and agriculture workers and fishermen have very low knowledge. Those who speak Thai have better knowledge of HIV/AIDS.

8. Misperception of HIV/AIDS is very common in this population. Many people believe that HIV is transmitted by casual contacts such as touching, sharing house or clothes etc. They also believe in many wrong prevention methods (section 3.7-3.9). People with low education, low income, Buddhists and low Thai language comprehension are more likely to harbour these misperceptions.

9. Overall 22.5% of the respondents had casual sex outside their usual couple over the last year. Both single and married men are likely to be involved in casual sex with married and divorced/widowed women (section 4.8). This is a surprising finding for married people most of whom stay with their families. Casual sex is especially prevalent among people with high income and those stay with same sex friends.

10. There is a small commercial sex industry with about 20-25 indirect sex workers. Most of them are Burmese and work in restaurants, karaoke or traditional massage. Their usual clients are local Thai officials, traders and a few wealthy residents. Very few of the migrant workers can afford to this relatively expensive services.

11. Condom use is very low (section 3.8). In casual sex, it is 'always' used in 12.5% cases, 'sometimes' in 6.9% and 'never' in 80.6%. Condom use is almost non-existent in regular partner sex e.g. husband-wife or boyfriend-girlfriend. Low knowledge and poor acceptance of condom as well as availability are cited among the main reasons for low use.

12. Eleven or 3.4% of the respondents - eight men and three women - admitted using injecting drugs. They are of various age groups (mean 25 years). Nine of them are Mon, one Karen and one Burmese. Four work in agriculture, three in fisheries, two in construction and the rest in other occupations. Six of them shared needles for injection. In addition, 15% of the respondents used injections for the treatment of their illnesses over the last year often administered by unqualified personnel.

Health and HIV/AIDS services

13. 88% of the respondents know about health care services in Sangkhlaburi and most go to government hospital and clinics and some to the private Christian Missionary Hospital (section 3.8). 85% have no problem with Thai hospital, 9% complain about high cost and a few cited language and other problems.

14. Privately run Christian Missionary Hospital plays an important role in the heath care of the migrants and refugees in the area. This is specially favoured by the Karen Christians and people who do not speak Thai well. They also have some special services for the migrants e.g. rehabilitation centre for the physical and mentally disabled people.

15. While MSF and ARC are NGOs not involved in the services for the migrants in Sangkhlaburi but they have an important role in the health care of the refugees in the camp including deported or repatriated migrants from central Thailand. They act as a bridge between both sides of the border and are important link with the Mon and Karen social organisations.

Finally, the findings of the multivariate analysis of the factors determining HIV/AIDS situations in Sangkhlaburi are presented in Figure 3.19. It shows a number of variables having effects on higher knowledge of HIV/AIDS, and some variables that are related to higher likelihood for casual partner sex.

Figure 3. 19: Factors Determining HIV/AIDS Situations:
Findings of the Multivariate Analysis

1. Factors determining HIV/AIDS knowledge, prioritised by sequence as follows:

Higher education	- higher knowledge
Religion: Christian	- higher knowledge
Occupation: factory	- higher knowledge
Places of origin: Yangon	- higher knowledge
Accommodation: stay alone	- higher knowledge

2. Factors determining risk through 'casual partner sex' are as follows:

Income: high income	- higher likelihood
Accommodation: same sex friends	- higher likelihood

Discussions

Migration pattern

For the last several decades, Sangkhlaburi has been known as an area of migration for ethnic minorities from neighbouring Myanmar. The first major exodus occurred in the late nineteen forties following an uprising for an independent Mon state and resultant armed conflict in the area. Many ethnic Mon migrated and settled in Sangkhlaburi and several other nearby provinces. Some of them now have Thai nationality. Since then more and more Mon and Karen continued to enter Thailand. While some of them stay in the several refugee camps along the border, others have become migrant workers in Thailand. There is a certain overlapping between people in the camps and the migrant workers, and in recent years migrant workers have overshadowed the refugees in the area. Most of the migrants use their personal contacts and information in making decision to come to Thailand. There is hardly any organised agency to help them with information and travel arrangement inside Myanmar. There are three distinct categories of migrants in the areas based on their intended destinations - (i) those who stay and work in Sangkhlaburi, (ii) those who stay in the refugee camps, and (iii) those who travel to central Thailand for jobs. However, significant overlapping exists among these groups depending on their original intentions, financial capacities, contacts at their destination and travel arrangements. In recent months migration beyond Sangkhlaburi has been drastically reduced due to stringent immigration control, and many of those who earlier migrated to those destinations have been deported or repatriated to Sangkhlaburi by the immigration officials.

Ethnically, most of the migrants in Sangkhlaburi are Mon and Karen with relatively smaller numbers of Burmese. Over 50% of the migrants have lived in Sangkhlaburi for over five years and many of them have pink, orange and blue immigration cards (section 3.1). As a result, most of their migrants have their families with them and developed into several migrant communities in the district. 85% of the migrants do not intend to return home. As it is a rural area, agriculture is the main occupation of the vast majority (58%) of the migrants. Relatively smaller numbers of people are employed in fisheries, service and domestic help, construction and day labouring. Overall, migration process is slow in Sangkhlaburi which means people come and stay for a long time. It is not as rapid or transitory like other border areas and there are only a few commuters in the area.

Gender and marital status

Like many other parts of the region, migrant women in Sangkhlaburi are generally submissive to men. Literacy, job and income opportunities and access to information for women are rather limited. Average monthly income of men is 2,016 baht compared to 1,807 for women. Men also have better knowledge about HIV/AIDS than women. Because of their low knowledge, women also have very strong negative attitude towards PWHAs. These gender differences, in regard to issues related to sexual behaviour and acceptable norms, have been clearly demonstrated in this study (section 3.7-10). The study found that both married men and women have casual sex but it is more common for single men than single women. But it is often the man who decides whether to use a condom or not but the women bear the 'real' consequences. Women in this rural society usually shy away from buying condoms and

solely rely on their partners to bring one. Overall women have very little or no choice for safe sex, and in many instances they are infected through their partners. These issues should be highlighted in the programme activities and support should be given to women to improve their role and bargaining power in the social and sexual life.

Influence of Ethnicity and Religion on Knowledge of HIV/AIDS

Ethnicity and religion have great influence on local traditions and cultures. People tend to adhere to these values and consciously or subconsciously resist deviation from these norms. There have been a lot of discussion about the role of religion in the context of the HIV/AIDS epidemic. In Sangkhlaburi, Mon Buddhists have lower knowledge about HIV/AIDS compared to the Karen Christians. This apparent lower knowledge is generally relevant to the lower education of the Mon as well as lack of access to information. Similarly, Buddhists have more negative attitude towards PWHAs than the Christians. But in terms of 'safe sex' practice or casual sex, the study failed to identify any significant differences between the ethnic and religious groups. Nonetheless, careful attention should be given to the ethnic and religious differences of the population in HIV and other health and social programme.

Misperceptions of HIV/AIDS

Like many other people, misperceptions relating to HIV transmission and prevention is a serious problem among migrants in Sangkhlaburi. Even some people who understand well about methods of transmission such as sexual contacts, blood transfusion or sharing contaminated needles, they still harbour the wrong perception that HIV is transmitted by casual contact such as touching, sharing a house or toilets etc. In many instances, these misperceptions arise from rumours and hearsay from friends and peers. In Sangkhlaburi, a great majority of people have misunderstandings about transmission and prevention (sections 3.7-3.9) which has led to a negative attitude towards PWHAs. Over 95% of the respondents disagree to live with a HIV-positive person and 76% suggest to isolate them from normal people. More than half of the respondents (57%) state that they would not visit a friend who become HIV-positive. These attitudes have their origin in how people learned about HIV/AIDS, without clear clarification about casual contact or misperceptions about prevention. All HIV/AIDS prevention workers talk about condoms and how it prevents HIV but few of them talk about what the people fear most i.e. casual transmission. Information in this study will hopefully help to develop new ideas for HIV programmes.

Slow transmission of HIV

Finally, we take a close look at the HIV/AIDS situation at Sangkhlaburi. Unlike many other cross-border locations, Sangkhlaburi has its unique 'risk situation' for HIV transmission. This is not a well-known place for commercial sex because of the poor local economy of the migrants, limited border trading and emphasis on eco-tourists most of whom are not inclined for commercial sex. A small number of indirect sex workers provide services mainly to local Thai officials, wealthy residents and some traders. Only a few migrants visit these establishments. However, casual partner sex are prevalent in this population and 22.5% of the respondents have admitted such relations over the last year. Interestingly in this

predominantly rural settings and stable migration situation more married people reported casual sex (23.9%) compared to only 15.4% of the single people. Some of these casual sex encounter occur between Sangkhlaburi migrants and mobile people who go elsewhere in Thailand and have increased vulnerability to HIV/AIDS. In fact, some of the Sangkhlaburi migrants also go to work elsewhere in the province and central Thailand. Women migrants who work in the domestic, hotel, restaurant and entertainment services are believed to be vulnerable to high risk situations. Overall condom use is very low in all non-commercial sex ranging from none in regular couples to only 12.5% in casual partner sex (section 310). In addition IDUs are also prevalent in certain groups, and 11 out of 327 or 3.4% of the respondents have admitted to its use, including six who shared needles.

So slow but consistent HIV transmission is occurring among in this population. With the exception of few sex workers and their Thai clients, it is difficult to identify any specific population groups. But because of their low knowledge both lake fishermen and agricultural workers are considered vulnerable to HIV/AIDS. Very limited HIV testing data available from both Sangkhlaburi and the Christian Missionary hospitals indicate gradual increase in the number of cases (section 3.3). Some HIV-positive cases are also reported from the refugee camps mostly through blood donor screening. However, such HIV testing data is inadequate to give a full picture of the situation and it is feared that the epidemic might has already spread in the larger population.

Health and HIV/AIDS services

As most of the migrants have been living in Sangkhlaburi for a long time they are quite familiar with the Thai health system. Existing government health services provide emergency health care to all migrants. They also provide outpatient treatment and maternal and child health services. Despite language difficulties, the migrants are generally happy with the services they receive in the hospital and tambon clinics. Some smaller number of people go the Christian Missionary hospital. Predominantly Buddhist Mon prefer the Thai hospital but Christian Karen prefer the missionary hospital. In any event, public health services and Christian hospitals have very limited services for the HIV/AIDS education and prevention for migrants. Two main foreign NGOs, ARC and MSF, who assist health care in the refugee camps are not involved with the migrants in Sangkhlaburi. They acknowledge a growing problem of HIV/AIDS in the refugee camps and among returnee migrants. They are, however, yet to come up with any significant HIV/AIDS prevention and care programme for the refugee population. If this happens in the future, then it might be useful to integrate their camp activities with a programme for the migrant population. Possible areas of such collaboration are development and production of IEC materials and joint training of peer educators and volunteers.

Study Recommendations

The main purpose of this study is to provide an analysis of the HIV/AIDS situation of migrant and mobile populations in Sangkhlaburi. In making recommendation one should bear in mind that the migrants live, work and interact with the local Thai people, their employers, health staff and police, immigration and other government officials. They understand well about their situations, organisational capacities and available resources. In many respects,

these local agencies play a key role in the development of intervention programmes. It is therefore that the following recommendations should be viewed as a general guide for discussion with the (proposed) local and national working groups to develop strategies for specific intervention programmes in the area.

1. **Formation of a "local working committee" for migrant populations:** At the district level, a "local working committee" should be set up to coordinate activities related to the migrant workers. The main purpose of this committee will be to develop and/or improve health and HIV/AIDS services for the migrant population. This 'decentralised' committee should include but not be limited to representatives of the migrant community, relevant government agencies such as police and immigration department, health, labour and social welfare offices, Christian Missionary hospital, MSF, ARC, BBC and other NGOs and civil society groups. The committee should have a degree of autonomy to deal with local issues and should be allowed to raise local funding and use it for local purposes, and implementing necessary cross-border collaborations at the local level. The committee should be linked with and receive support from the provincial and central policy making bodies.

2. **Organisation of a local workshop:** As an initial stage for the formation of the proposed local committee, a workshop should be organised in Sangkhlaburi involving all potential partners. The workshop should discuss the findings of this study and its recommendations as well as the structures, functions and funding of the proposed committee. The committee and its partner agencies should then prepare a detailed work plan and implementation modalities of their activities. This meeting will also be an important first step for the dissemination of the information to the local audience.

3. **Migrant People and community level:** Many migrants have been living in Sangkhlaburi for several years and are concentrated in several migrant communities. In some communities, local Buddhist monks have played a key role in promoting this community level initiatives. Lessons learned from some of these initiatives could serve as a valuable example for the strategies and approaches to community level responses in this area. Some additional suggestions at the community level are -

- **Peer education programme:** Assess the scope and feasibility of trained peer education programme in various vulnerable population groups e.g. agriculture workers, fishermen, sex workers, construction workers and housewives in the community. This is considered to be one of the main components of any intervention strategy in the area.

- **Community mobilisation:** Review and assess the strengths and weaknesses of the community structure and capacity to undertake their own initiatives e.g. Mon community. Facilitate community based activities by providing technical and organisational inputs and some material support to selected communities in the area.

- **Targeted interventions:** In some instances where peer education and community mobilisation are difficult to begin with, specific targeted interventions by outside agencies should start for these specific vulnerable groups e.g. sex workers and new arrivals to Sangkhlaburi. Public health office and NGOs should also partnership with the drug stores on rational prescriptions for STDs as well as condom sale.

- **Focus on life-skills:** It has been elsewhere that increased knowledge does not always change behaviour. It is therefore imperative that HIV/AIDS projects should focus creating understanding about peoples' own vulnerability and methods for their prevention and care. Participatory learning and activities (PLA) and other similar exercises with the people should be useful in some of these situations.

- **Gender sensitive approach:** It has been identified that the women have subservient role in the community. They also have low knowledge of HIV/AIDS and are perhaps, inadvertently getting infected. All existing and future programmes should develop strategy that places equal emphasis on men and women so that they can make their own decisions. Programmes involving women and their leaders will help to achieve these objectives.

4. **Public health services:** Most of migrants are familiar with the government health services and in general seeking health services there. This is the result of their long stay in the area and their desire to stay permanently in Thailand. In addition to their current services the public health department should explore possible expansion of its services to provide health education including HIV/AIDS awareness to the migrants. They may however need to develop multilingual IEC materials and hire Mon and Karen speaking interpreter or volunteer to assist in their programme. They may coordinate these activities with the NGOs working in the district (see below). If necessary, the district hospital may raise local fund by implementing existing Thai health cards or social security scheme in the migrant population.

5. **Programme for vulnerable Thai population:** Public health office should take a note of the local Thai officials and residents' involvement in the commercial sex industry in the district and develop appropriate awareness and prevention programme for the sex workers as well as Thai clients. In dealing with the non-Thai speaking Myanmar sex workers, it might be useful to involve an NGO with their trained multilingual staff.

6. **NGOs programme:** Christian Missionary Hospital should explore its potential role for heath education including HIV/AIDS awareness for the migrants in the area. It may work with the district health office, MSF and ARC for the development of multilingual IEC materials, and training of the peer educators or volunteers for the community level activities. MSF, ARC and other NGOs role is crucial for the services to the refugees in the camps and surrounding areas as well as migrants who are deported and repatriated to the area. Together these NGOs could be a bridge programmes on both sides of the border.

7. **Cross-border collaboration between the opposing border towns:** There are some areas where cross-border collaboration could be very useful in Sangkhlaburi. However, such an approach should be as practical as possible so that the issues can be effectively dealt at the local level. Existing cross-border mechanisms between NGOs and Phyathongsu hospital and Maternity and Child Welfare Association (MCWA) should be reviewed to attain the best possible results from it. Some areas of possible collaboration are – sharing information about communicable diseases including HIV/AIDS, IEC materials and referral of patients. However, it should be kept in mind that in most instances, the intervention programmes can be developed on one side of the border without much involvement from the other side. One should not overemphasise the importance of cross-border collaboration at this stage but wait

for a suitable time and opportunity by gradually building trust and confidence among agencies working on both sides of the border.

8. Collaboration with the places of origin and destination of migrants: Many problems that the migrants face in Sangkhlaburi are related to inaccurate information they receive before their departure. It will be very useful to explore the possibility of setting up a programme to disseminate important information including HIV/AIDS to the potential migrants in Myanmar before they depart home. The scope of such programme may be limited only to areas with large number of emigrants. This could be a part of the cross-border collaboration or separate from it depending on the site and extent of the programme. In this approach the agencies in Myanmar from where migrants originate will have full range information including the problems they face in Sangkhlaburi and Thailand in general. The agencies will then disseminate these information to the people through various channel appropriate for their situations. In addition, the agencies should also explore the needs and opportunities for project to support the returnee migrants including PWHAs if any.

9. Formation of national committee on migrant population: Similar to the provincial committee, a multisectoral committee could be formed at the central level to discuss the health and HIV/AIDS among migrants and in the border areas. Possible functions for the proposed committee can be to develop strategic planning, technical support and fund raising for the projects to be implemented at the local level. These committee should also deal with the national level authorities to develop necessary policies on health care services for the migrant populations. Policies should be clear, precise and practical so that it is possible to implement these at the provincial and district levels. These policies should become an integral part of the overall policies on migrant populations in the country.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

CHAPTER IV

CROSS-BORDER MIGRATION AND HIV VULNERABILITY AT RANONG-KAWTHAUNG

4.1 BACKGROUND INFORMATION

Ranong is one of the coastal provinces in the southern region of Thailand (Map 1.1 and 1.2). Parts of the province are covered by forest and tropical orchards. It has a long coastal line with the Andaman sea which has been developed into a very rich fishing industry over the years. Ranong borders with the Tanintharyi division of neighbouring Myanmar. The main border crossing is Ranong-Kawthaung, a three kilometres wide water passage separating two countries. A large number of boats, which are both Thai and Myanmar registered cross through this passage. A one-way boat trip usually costs 30 baht excluding immigration fees of 50 baht on each side of the border. The sea in Ranong-Kawthaung is also famous for hundreds of large fishing boats from both sides of the border that criss-cross the sea.

There are five districts in the province. A great majority of the people live in the Muang and Kraburi districts. Muang district is also the heart of the local economy and commands a significant influence over rest of the province (see Map 4.1).

Table 4.1: Thai Population in Ranong Province

Districts	Population
Muang Ranong	73,361
La-aun	11,298
Kapur	17,546
Kraburi	41,724
Suksamran	4,795

Source: Governor's office, Ranong

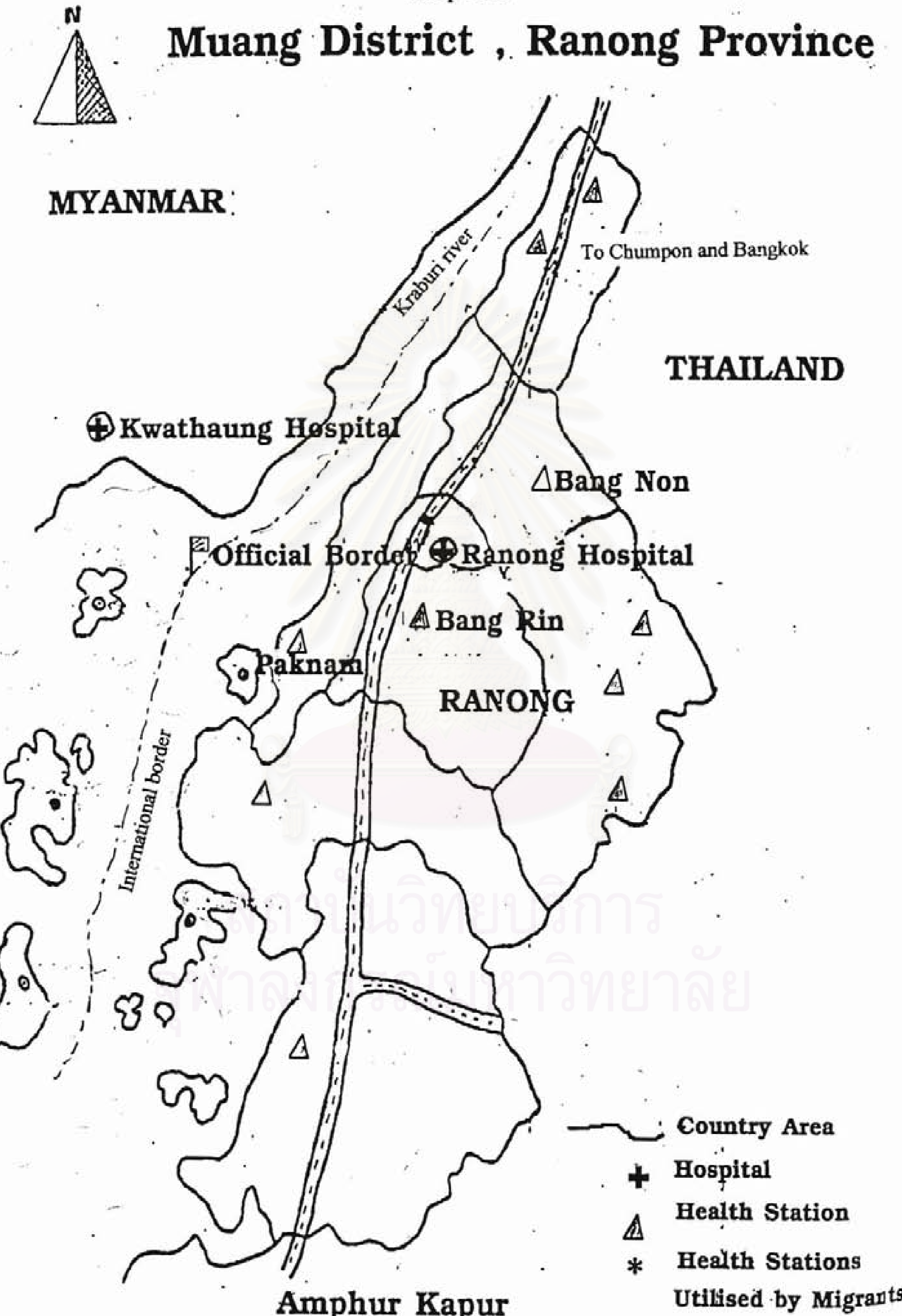
A great majority of the Ranong population is Buddhist (80.8%). 16.4% are Muslim, 1.9% Christian and 0.94% of other religions. Like in the rest of Thailand, people follow various religious and cultural ceremonies. The Ranong Cashew Nut Festival is famous for its unique plantations and high quality products.

Trade and Economy

Although the majority of the Ranong population works in the agriculture sector (19%), fishing (6.7% workforce) and related industries are the main source of local income. The fishing industry also hires a large number of labourers for fish related activities. The province also has significant rubber and fruit orchard plantations. Poultry and cattle raising are other two sources of income. Unlike its neighbouring provinces like Phuket, Phanga or Krabi,

Map 4.1:

Muang District , Ranong Province



tourism is not so active in this province. Still many Thai tourists visit the province along with a fewer foreigners. Cross-border trading with the people of Myanmar is also another important part of the local economy. Because of the sparse population in the southern part of Myanmar, export from Thailand is not as active as in Mae Sai-Tachilek or Mae Sot-Myawaddy. Cross-border logging from Myanmar to Thailand was very active in the past but has ceased in recent years because of environmental concerns and the consequent pressure from lobbyists.

The Burmese continue to sell fish, crab, dried fish, charcoal, rattan products, but also foreign liquors, cigarettes and souvenirs. Thais export cement, vegetable oil, gum, bicycles, aluminium, electrical appliances, household consumer goods and local food products, as well as tractors and motorcycles. The official trade volume between the countries is given in Table 4.2. It shows that Thailand continues to enjoy a positive trade balance. The cross-border trade volume is considered as an indirect measurement of the traders and businessmen visiting the area. They very often form an important client group of the local entertainment venues including commercial sex. In addition, a large number of Myanmar visitors and migrant workers in Ranong spend a lot on consumer goods, house rental and many other businesses.

Table 4.2: Trade Volume at Ranong-Kawthaung in Million Baht

Year	Import	Export	Trade Balance
1995	684.01	2,158.52	1,474.51
1996	133.83	1,843.24	1,709.41
1997	266.02	2,377.37	2,111.22
1998	286.00	2,838.65	2,552.65

Data Source: Custom office, Ranong

Immigration, Border Control and Local Relations

Ranong Province has a long border with Myanmar. The only official immigration check point between the countries is at Ranong-Kawthaung. Thai people with a border pass can only go for a day trip to the adjacent areas in Kawthaung. Those with a passport can stay overnight and may travel beyond the area. Similar regulations apply for Myanmar nationals. Immigration authorities on both sides of the border collect a border crossing fee of 50 baht per person for Thai and Myanmar nationals. With an immigration pass, however, the Myanmar people are allowed to stay up to a week in Ranong.

In addition to Ranong-Kawthaung, there is another border crossing point in Kraburi district. The numbers of Myanmar people crossing the border in both Ranong and Kraburi are given in Table 4.3. However, the number of people crossing in Kraburi are much smaller than those in Ranong. In addition, there are several other forest trails which can be used for illegal entry into Thailand as this border between the two countries is very porous.

Table 4.3: Myanmar Nationals Entering Ranong Province, 1998

	Ranong			Kraburi		
	Male	Female	Total	Male	Female	Total
January	7,460	4,420	11,880	2,542	1,100	3,642
February	7,800	3,570	11,370	1,649	1,235	2,884
March	7,416	4,584	12,000	1,321	763	2,084
April	6,492	5,478	11,970	736	536	1,272
May	7,632	5,328	12,960	885	551	1,436
June	6,798	4,182	10,980	816	256	1,072
July	7,614	4,716	12,330	736	366	1,102
August	8,502	4,572	13,074	1,484	544	2,028
September	8,670	4,270	12,940	1,110	512	1,622
October	8,196	4,272	12,468	1,054	350	1,404
November	7,716	5,484	13,200	520	342	862
TOTAL	**84,296**	**50,876**	**135,172**	**12,853**	**6,555**	**19,408**

Source: Ranong Immigration Department

Migrant and Mobile Population in the Area

Local authorities estimate that there are about 100,000 migrants in Ranong Province (Table 4.4), about 80% of them in Muang district. Kraburi district has another 15-18,000 migrants. There are only a few migrants in three other districts. A majority of the migrants are employed in the fishing industry and fish related businesses including fish sauce, canned fish etc. plus sea transportation. Another large group works in the service sector such a retail businesses, hotels and restaurants, sex and entertainment venues and domestic services. Seafarers are all men but a many workers in the fish related industry are women. Women also form the large bulk of the service and domestic helpers. In addition, there are a large number of family members who accompany the workers, estimated to be about 20% of the total migrant population in the province. These family members include mostly women and

Table 4.4: Estimated Number of Migrant Workers in Muang Ranong

Occupation	Estimated number	% of estimate
Agriculture	2,200	2.8
Fishing	27,000	34.8
Fishing related	13,500	17.4
Construction	1,200	1.5
Water Transportation	1,800	2.3
Manufacturing	1,900	2.5
Service and domestic helpers*	14,400	18.6
Family members**	15,500	20.0
Total	77,500	100.0

Source: Chamber of Commerce and Chamber of Industries, Ranong; Total number of migrants in the province is about 100,000 that means 22,500 live in other district.

** There are about 500 migrant sex workers in Ranong often mixed with the service girls.*

*** World Vision estimate of unemployed family members.*

children, and only a few of them work in any formal jobs. This large concentration of migrants in the province has encouraged the development of several migrant communities with their unique characteristics (see Burmese Community).

According to the local authorities, there are only 16,039 registered migrant workers in Ranong (Table 4.5) of which a great majority are Burmese and only a handful are Laotians and Cambodians. This number represents about 16% of the total estimates of the migrants (see Table 4.4), which means that a large number of people remain undocumented. This is especially common among fishermen and workers in the service sector where only a few are registered. It is important to note that 36.6% of these registered migrant workers are women which is consistent with the national average of 30% female registered migrant workers (Paul S.R, 1998). Migrant women are not only employed in the domestic services but also in non-traditional jobs such as agriculture, fishing related, manufacturing, construction and water transportation (Table 4.5).

Table 4.5: Registered Migrant Workers in Ranong Province

Occupation	Male	Female	Total
Agriculture	4,023	1,624	5,647
Fishing	303	68	371
Fishing related	2,134	2,145	4,279
Construction	2,240	379	2,619
Mining	112	5	117
Manufacturing	724	161	885
Service and domestic helpers	32	1,218	1,250
Water transportation	598	273	871
Total	10,166	5,873	16,039
% of Total	63.4%	36.6%	100%

Source: Department of Labour and Social Welfare, Ranong;

In addition to the large number of migrant workers in the province, Ranong is also a major entry point for thousands of Myanmar migrants working in the southern and central provinces of Thailand such as Phuket, Trang, Chumpon, Surathani, Songkhla, Samut Sakhorn, Samut Prakan, Bangkok and other areas near Bangkok. Many of these workers often live and work in Ranong first and then seek an agent to take them to their intended destinations. Some of them travel up to Malaysia and Singapore for better paid jobs compared to what they would receive in Thailand. Ranong is both a place for employment and the launching pad for higher paid jobs in Thailand and beyond. Fishing companies in Ranong have an 'official joint fishing contract' with the government of Myanmar that allow them to employ Myanmar fishermen on Thai fishing boats. There is a slight seasonal variation in the number of migrant labourers in Ranong e.g. fishing and related jobs drop during the monsoon rainy season, and increase for the seasonal plantation and harvesting. More construction workers are needed for the large building or infrastructure development projects. Migrant numbers also depend on police and immigration crackdowns. It also depends on the police activity who control departure of the migrant from Ranong to inner provinces.

Deportation of Illegal Migrants in Ranong

Most of the illegal migrants from Myanmar who get arrested in Thailand are sent to the IDC in Bangkok but also to the prisons in other provinces. They are then deported through one of the three cross-border points with Myanmar, namely, Sangkhlaburi, Mae Sot (Tak province) and Ranong. However, those arrested in the three deporting provinces are kept there and are not sent to Bangkok. Ranong receives a significant number of deportees from central and southern Thailand. The deportees are transferred from the Bangkok IDC to the Ranong IDC where they have to wait for a few days to weeks before being sent to Kawthaung. The duration of the deportation process depends on the number of detainees at any one time. Usually, a deportation trip is organised once the number of detainees reaches about 50 to 100. The larger the number of detainees, the shorter is the time they have to wait in Ranong. Table 4.6 shows the number of migrants arrested and repatriated through the official channel in Ranong. Arrests in Ranong are quite irregular and do not seem to have any clear pattern. On the other hand voluntary repatriation was quite active in the middle of the year. According to local informed sources, these arrests and repatriation usually follow political upheavals at the national level but also important local incidents e.g. criminal activities or reports of epidemics.

Table 4.6: Arrest and Repatriation of Migrants in Ranong in 1998

	Jan	Feb	Mar	Apl	May	Jun	Jul	Aug	Sep	Oct	No	Tot
Arrested outside	1757	3009	1836	1205	971	971	753	702	190	457	494	
Arrested in Ranong	138	332	42	-	-	50	467	287	-	-	377	
Voluntary repatriation	-	-	396	238	702	383	1320	726	300	547	580	

Source: Ranong Immigration office

4.2 HEALTH SITUATION AND HEALTH SERVICES

Ranong is a small province and the health situation here is similar to many other southern provinces of Thailand. Like the rest of Thailand, the province has eradicated most communicable diseases such as Malaria and Filariasis. Other common illnesses are diarrhoea and respiratory infections. Tuberculosis is still a problem among certain population groups and reported to be increasing along with the HIV/AIDS epidemic. In recent years, some new cases of Malaria and Filariasis have been reported mostly among migrants, which are thought to have been imported from Myanmar.

The province has relatively well developed public (government) and private health sector services. The public health system consists of a provincial hospital, district hospitals and a network of *Tambon* (sub-district) health stations. Private health sector services consist of a hospital, NGOs providing health care to the migrants, a large number of drug stores and some traditional healers. Patients from these NGOs supported services are referred to both hospitals in Sangkhlaburi.

Ranong Provincial Hospital

Table 4.7 shows a glimpse of the patient statistics of the Ranong hospital with a breakdown of Thai and non-Thai patients. Non-Thai patients include migrant workers and their family members. Although it is only a small proportion of the overall case load in the hospital, it is however a significant burden for a busy hospital especially because the migrants usually do not speak Thai. Many migrants also can pay for the treatment and hospital has to bear the costs within their usual budget that covers only Thai patients. The government does not have any special budget for migrant workers and the public health department has yet to develop any effective method of providing finance.

Table 4.7: Number of Thai and Non-Thai Patients in Ranong Hospital, 1994-98

	1994	1995	1996	1997	1998
Thai patients	89,055	124,100	129,321	134,459	144,717
Non-Thai patients	4,641	5,228	4,189	7,471	5,471
TOTAL	93,696	129,328	133,510	141,930	150,336
Non-Thai In-patients and Out-patients in Ranong Hospital					
Out-patients	2,393	4,379	3,108	3,355	3,012
In-patients	2,248	849	1,081	843	821
TOTAL	4,641	5,228	4,189	7,471	5,471

Source: Ranong Provincial Hospital

The available breakdown of hospital delivery records, however, shows that there are more Thai patients than non-Thai (Table 4.8). The number of Thai patients are steadily declining because of overall decline in birth rate in Thailand. Delivery of non-Thai is not declining perhaps because of two reasons i.e. gradual increase of Burmese population in Ranong as well as low usage of birth control methods. The in-patient service comprises of 30 beds and includes care for all common illnesses and minor surgeries. Patients with major surgical problems are referred to Kanchanaburi. The hospital also has a good laboratory and blood screening facility for transfusion purposes. Outpatient services include treatment for common illnesses, follow-up of chronic or long-term illnesses such as tuberculosis, maternal care and children immunisation. In addition to the district hospital, the government's *Tambon* clinics provide primary care to Thai and non-Thai patients. Public health services have HIV/AIDS education services throughout all of its offices. Patients are required to pay for the services and only the poor who can not afford the costs may seek social service supports. Patients who are referred by NGOs from the refugee camps are covered through the particular NGOs. No data is available to show what proportion of non-Thais did not pay for the services. Overall, public health services are the main provider for migrants in the area.

Table 4.8: Thai and Non-Thai Deliveries at Ranong Hospital, 1994-98

	1994	1995	1996	1997	1998
Thai	2,600	2,627	2,611	2,320	2,307
Non-Thai	740	834	1,097	874	817
TOTAL	3,340	3,461	3,708	3,194	3,124

Source: Ranong Provincial Hospital

World Vision Clinic

The World Vision clinic is the main health care provider for migrants in Ranong. It is located near the port area surrounded by most of the migrant fishing communities. This clinic is jointly operated by the Ministry of Public Health and World Vision Foundation of Thailand (WVT) and is open five days a week. Its OPD services are open in the morning but only emergency services are provided in the afternoon. It has a few observation beds but no in-patient facility. The clinic provides treatment for common illnesses, *STDs* and minor surgical care. Once a week, the clinic offers MCH services for mothers and children including EPI immunisation. Voluntary counselling and testing for pregnant women provided at the clinic. They also give testing and counselling for suspected HIV/AIDS positive individuals.

The most important activities of the WVT project are the organisation of education and awareness about HIV/AIDS in the migrant communities. This is done through the PHC approach by mobilising the migrant communities and working with them to identify and solve their problems such a sanitation, water supply, training, and equipping the TBAs for home delivery, education for children, safe-guarding of savings etc. People find the project supportive of their day-to-day issues and not an outside interference of HIV/AIDS education. The project also supports other community activities, and traditional festivals to boost the morale and dignity of people. At present, the project covers six fishing communities of about 15,000 people, although HIV/AIDS and health information messages go out to a larger audience but certainly not to all estimated 100,000 migrant people in the province.

The project also serves as a 'bridge' between the two sides of the border i.e. Ranong and Kawthaung, and promotes cross-border cooperation. Through its sister agency, World Vision Myanmar (WVM), WVT facilitates regular information sharing between Ranong and Kawthaung government health officials, warns of epidemics on either side of the border, and promotes patient referral from Ranong to Kawthaung mostly for those suffering from chronic illnesses including HIV/AIDS. They also work together to develop IEC materials and sometimes joint programme reviews and staff training activities.

Private Hospital and Clinics

There is one large private hospital in the district that provides curative care. This hospital is equipped with modern facilities and a comprehensive range of services. It is rather expensive and beyond the reach of many Thais and certainly for a vast majority of migrants. In fact, the private hospital is not a treatment option for the migrant labourers.

There are several doctors' clinics in town that provide consultation and out-patient treatment. Though expensive, a few well to do migrants avail services there because of their convenient location and working hours in the evening when people return from work. These clinics are not, however, a heath care option for many migrants.

Drug Stores

There are many drug stores in Ranong town. Most of the drug stores provide over the counter prescriptions and dispense drugs and supplies. In addition to the common fever and cold medicines, all drug stores provide antibiotics for common illnesses including *STDs*. Usually,

they would not give antibiotic injections but some of them would do so for an extra income. Overall, drug stores are popular places to seek health care services for many migrants.

Migrants also have their traditional healing practices and some healers are available in the migrant communities. These healing practices range from coin rubbing, to various forms of massage and herbal treatment. A significant number of abortions occur in the communities and many of these are reportedly induced by traditional methods (Paul S.R et al, 1997).

Kawthaung Hospital

This 60 bed hospital is the largest in the nearby area of Myanmar. It provides both out and in-patient care. In addition to the treatment for common illnesses, the hospital and its community outreach programme offers preventive heath care services such as MCH and immunisation. It has a special *STD* clinic and HIV testing is available for selected groups such as blood donors and pregnant women. It is one of the sites for nation-wide HIV sentinel surveillance. Blood transfusion facilities are available in the hospital. Disposable needles and syringes are used for injections. Only minor surgeries are performed in the hospital. Delivery services are also available but hospital delivery is not favoured by many people and home delivery by the TBAs is still quite common in the area.

4.3 HIV/AIDS SITUATION IN RANONG

Like in many provinces of Thailand, HIV/AIDS is a serious problem also in Ranong. It has also been identified as a major problem among migrant population. Ranong has a very large commercial sex industry and vast majority of the sex workers are migrants from Myanmar providing services mostly to the migrants but also to significant number of Thai population. Before 1994, a great majority of these services were provided in the brothels and often without provision for safe sex i.e. no condom and not treatment for *STD*s. This has resulted in rapid spread of *STD*s and HIV in the sex workers and their clients. The clients eventually transmitted the disease to their spouse or other partners. At present, HIV/AIDS is prevalent among large number of migrant people and are not necessarily dependent on the commercial sex for its transmission.

Over the past years, the number of HIV/AIDS patients among both Thai and migrants has been increasing in the province (Table 4.9). It also reveals that there was a significant number of cases in 1997 but the number decreased slightly in 1998. This trend is also similar among Burmese migrants. However, it is not quite sure if these statistics cover all HIV/AIDS patients as more and more Thai people seek private treatment especially home care.

Table 4.9: Thai and Burmese AIDS and Symptomatic HIV Patients

	AIDS Patients		Symptomatic HIV	
Year	Thai	Burmese	Thai	Burmese
1992-96	150	77	102	42
1997	143	51	54	22
1998	126	45	6	7
TOTAL	592	304	183	96

Source: AIDS/STDs Office, Provincial Health Department, Ranong

Thai national HIV sentinel surveillance in the province provides a broader view of the prevalence in the sentinel groups. Results of two sentinel groups i.e. pregnant women and direct sex workers are given in Table 3.13 of the Sangkhlaburi report but also see Figure 4.1 in this section for a close comparison. These figures show two important findings: (i) HIV prevalence in Ranong is higher than the national average in Thailand, and (ii) the trend of HIV prevalence is levelling off in Ranong i.e. it is not rising anymore. These findings are consistent with many other locations in Thailand.

Table 4.10 shows HIV prevalence among Thai and migrant ANC clinic attendees in the district (note: samples are different from sentinel data). Overall HIV prevalence among migrant women is higher than Thai people. The HIV prevalence among Thai women is not also levelling off like Thai population elsewhere in the country and the last report in 1997 that shows infection rate of 3.48 is definitely worrying. In the first half of 1998, out of 208 ANC attendees in WVT clinics, 15 or 7.6% were HIV positive.

HIV prevalence among migrant sex workers was also very high between 1992-94 when testing was done regularly along with the Thai sex workers. HIV-positive rates among migrants ranged from 50-65% at that time compared to 30-50% among the Thai sex workers. Following closure of the brothels, HIV testing is conducted intermittently as it is more difficult to access the floating indirect sex workers. In 1998, among a large number of indirect Myanmar sex workers, the HIV-positive rate was found to be 33.77%. All of these HIV data illustrate the seriousness of the HIV/AIDS situation.

Table 4.10: HIV Prevalence among Thai and Migrant Pregnant Women

	Jun94	Dec94	Jun95	Dec95	Jun96	Dec96	Jun97	Dec97
Thai	1.50	1.82	3.09	2.43	2.39	2.17	3.17	3.48
Myanmar	3.10	6.67	3.13	5.00	3.22	3.52	3.52	5.36

HIV testing was also sporadically conducted among migrant fishermen from 1991 through 1997. These tests show an infection rate in the range of 7 to 22%. In 1998, a separate four site HIV surveillance study among fishermen showed an HIV infection rate of 16.1% among Burmese in Ranong and Samut Sakhorn. This is slightly higher than the 14.6% among Thais in all four sites but lower than 20.2% among Cambodians mainly in Trat (Entz A. 1998).

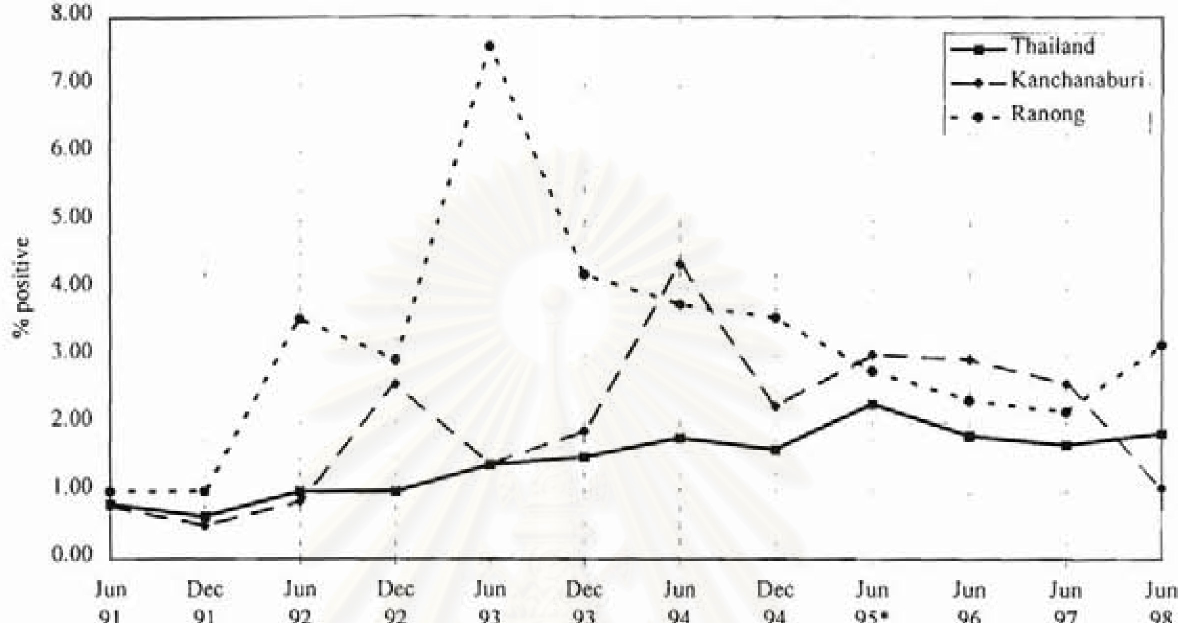
Table 4.11: VDRL Positive Syphilis in WVT Clinic in Ranong

Year	# of ANC Clients	Number of VDRL+	% of VDRL positive
1994	188	21	11.2
1995	520	35	6.7
1996	458	20	4.4
1997	372	10	2.7

There are some positive indications that *STDs* are declining in migrant pregnant women attending WVT clinics (Table 4.11). This is consistent with the nation-wide finding of a

decline in *STDs* prevalence in Thailand. Gonorrhoea and other *STDs* also decreased sharply in Ranong.

Figure 4.1: Mean HIV+ Among Pregnant Women, 1991-98



In summary, the HIV/AIDS situation in Ranong remains volatile and it is certainly a serious issue for the migrants. The infection rate among the local Ranong residents remains higher than Thai national average although it is showing some signs of levelling off, if not decline like in the rest of the country. By all accounts, HIV remains a complicated problem among some 'hard core' population groups such as fishermen and sex workers, as well as within casual partner sex, which requires further careful analysis and strategies for effective intervention.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

4.4 METHODOLOGICAL ISSUES

The research team were fully aware of the local situations as some of the key members work in a health and HIV/AIDS project in Ranong itself. Most of the interviewers are native Burmese speaker so there was no difficulty in the interpretation and communication with the respondents and key informants.

Study Period

The study preparations, including the development of the questionnaire, were done in November and December 1998. A three days field trip was made in December 1998 to collect background information on target areas and population, and to identify local teams, partners and interpreters. A two day workshop was organised in Ranong for the orientation and training of the local team and interpreters. It also served to review and test the KAP questionnaire, and to identify and contact key informants. Data collection was done in April 1999 followed by data entry and analysis in April and May 1999.

Scope of the Study

All respondents for structured interviews were chosen from the port area of Ranong where many migrants live in several communities. Other migrants live in sparse Thai communities and it is not so easy to arrange interviews with them. The study sample was selected according to proportional representation of each of the occupational groups provided of which estimates were given by the local authorities. So in addition to the fishermen who form a main portion in the migrant communities, the study sample is representative of the overall migrant population.

Constraints and Limitations

The study was conducted in a systematic manner and the team did not encounter any major constraints. The only limitation in the study was a lack of some qualitative information from the local health officials, employers and police and immigration officers which could have been beneficial in developing more specific recommendations for intervention strategies.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

STUDY FINDINGS ON MIGRATION

The following sections provide a detailed analysis based on the responses to the structured questionnaire of a 436 sample population. These analyses vary from simple frequency to cross-tabulation and correlation among variables. Some relevant qualitative information and analysis has been used in support of the quantitative data to elaborate the in-depth understanding of the issues. The main body of these findings is organised in the following three sections - demography, migratory experience, and HIV/AIDS risk situation.

4.5 DEMOGRAPHY OF STUDY SAMPLE

Of the total 436 respondents, 270 (61.9%) are male and 166 (38.1%) are female (Table 4.12). This gender breakdown is consistent with national data that shows that about 30% of undocumented migrant labourers in Thailand are female (see Paul S, 1997). The mean age of the respondents is 27.5 years (male 27.91 and female 26.90), and 70.0% of the men and 74.7% of the women are below 30 years of age representing a typical young migrant population. No respondent was selected below 15 years of age, which effectively left out minors and children in the quantitative analysis although they constitute a significant segment of the migrant population in Ranong. This is supported by the fact that 53.3% of the respondents live with their families and 22% of the married respondents had children born in Thailand.

Table 4.12: Age and Gender of the Respondents

Age Groups	Male		Female		Total	
(years)	Number	%	Number	%	Number	%
Below 18*	8	1.8	11	2.5	19	4.4
18 - 10	43	9.9	36	8.3	79	18.2
21 - 30	138	31.7	77	17.7	215	49.4
31 - 40	65	14.7	26	6.0	91	20.7
Over 40	16	3.7	16	3.7	32	7.4
Total	**270**	**61.9**	**166**	**38.1**	**436**	**100.0**

** this breakdown is used to show the internationally recognised age for child labour;*

Migrant Children:

In the Ranong migrant communities there are children of all ages and many of them are actually born in Thailand. Almost all of the children live with their nuclear or extended family. The migrant children are not usually allowed to go to Thai schools and many families continue to have private education in their native languages at home or with private tutors. In recent years some Thai community leaders allow limited number of Burmese children to enrol in Thai school. Most of the children help their parents and families with domestic work but there is no clear evidence of organised child labour in the area. Only 4.4% of the sample population is below 18 years of age and could by international standards be categorised as child labourers although Thai law allows children over 15 years of age to work in certain occupations.

Trafficking of women and children from Myanmar to Ranong was reportedly common in the past (WVT 1994, Asia Watch 1993). Many of these young girls were used in the commercial sex industry in Ranong and other parts of Thailand. There are several reports of inhuman treatment of Burmese girls in the brothels of Ranong, including death and killing of some of them. In recent years, trafficking for sexual exploitation has decreased significantly which is attributed to two main reasons. First, since 1994, the Thai government has been placing special emphasis to curb child prostitution in the country. There have been numerous raids and arrests, and eventual closure of large numbers of brothels in Ranong. Hundreds of young girls were rescued and many of them were eventually repatriated to Myanmar. Since then trafficking of young girls and direct sex services have significantly reduced. Second, following a revision of the Thai Prostitution Law in 1995, the government has vigorously implemented an old law that direct sex services in brothels are completely illegal. This resulted in a dramatic decrease in the brothel-based sex services. At present there are still many migrant sex workers in Ranong. But based on the existing information it is not evident if any of them are child prostitutes and/or trafficked or forced into this business (see sex workers, section 4.10).

Ethnicity and Religion

Burmese are the dominant ethnic group in Ranong, making up to 57.7% of the total respondents. Mon are the second largest ethnic group (18.4%) followed by Tavoy (11.7%) and Karen (5.3%) (Table 4.13). The ethnic mix here is quite different from Sangkhlaburi where most of them are Mon and Karen. Tavoy are ethnic southern Burmese but are considered different from the mainstream Burmese in the central region. Most of the Burmese migrants come from the Tanintharyi division of Burma, although there is a significant number of people from Yangon. Many Mon and Karen come from the Mon state because of its geographical proximity. Ethnicity plays an important role in the level of education, some occupation and access to information which are all important factors for the knowledge of HIV/AIDS/STD.

Like for the rest of Myanmar, Buddhism is the religion of the majority with 95.4% of the population followed by a small number of Christians and Muslims. Many of the latter group have ethnic links with the Rakhine state or Yangon. Most of the ethnic Burmese and Mon are Buddhists, and a large part of Karen are Christians. There are some distinct features in the life style of various ethnic groups that have been considered in the socio-behavioural analysis of the survey.

Table 4.13: Ethnicity and Religion

Ethnicity	Frequency	%
Burmese	251	57.7
Mon	80	18.4
Tavoy	51	11.7
Karen	23	5.3
Others	30	6.9
Total	**435**	**100.0**

Religion	Frequency	%
Buddhist	412	95.4
Christian	8	1.9
Islam	11	2.5
Others	1	0.2
Total	**432**	**100.0**

Education

The overall literacy rate of the sample population is 93.1% - male 95.6% and female 89.2% (Table 4.14) - which is better than the national average of Myanmar (82%). This is because of the fact that most of the people are Burmese who traditionally have a higher literacy rate than the ethnic minority groups in the country e.g. Mon. More women (62.7%) had formal primary level education compared to 43% of the men, although a significant number of men (20.7%) had more than nine years of education compared to only 2.4% of the women. So overall men have higher level of education than women.

Table 4.14: Level of Education by Gender

Education Level	Male		Female		Total	
	Number	%	Number	%	Number	%
No education*	12	4.4	18	10.8	30	6.9
1 - 5 years	116	43.0	104	62.7	220	50.5
6 - 9 years	86	31.9	40	24.1	126	28.9
Over 9 years	56	20.7	4	2.4	60	13.8
Total	**270**	**100.0**	**166**	**100.0**	**436**	**100.0**

** no formal education; some of them had monastery or other informal education*

Among the ethnic groups, Burmese and Karen have a better level of education than the Mon and Tavoy (Table 4.15). Almost one third, 31.1% of the Burmese and 43.5% of the Karen had a secondary level (6-9 years) of education compared to only 16.3% of the Mon and 23.5% of the Tavoy. This difference in the level of education among ethnic groups could be an important factor for the knowledge of HIV/AIDS and other health issues.

Table 4.15: Level of Education and Ethnicity

	Burmese		Mon		Tavoy		Karen		Others	
Level	No	%	No	%	No	%	No	%	No	%
No education**	16	6.4	61	7.5	2	3.9	39	17.4	3	18.8
1 - 5 years	116	46.2	42	62.5	31	60.8	46	39.1	4	25.0
6 - 9 years	78	31.1	21	16.3	12	23.5	15	43.5	5	31.3
Over 9 years	41	16.3	3	13.8	6	11.8	7	5.9	2	12.5
Total	**251**	**100.0**	**140**	**100.0**	**51**	**100.0**	**118**	**100.0**	**16**	**100.0**

Marital Status

Over half or 54.1% of the respondents are married (Table 4.16). There is a significantly higher proportion of single men (47.8%) compared to 25.3% of the women. This high number of single men could play an important role in the context of HIV situation in the area. There are slightly more divorcees and widows among women compared to their male counterparts.

Table 4.16: Marital Status of the Respondents

Marital Status	Male		Female		Total	
	Number	%	Number	%	Number	%
Single	129	47.8	42	25.3	171	39.2
Married	133	49.3	103	62.0	236	54.1
Divorced/Widowed	8	3.0	21	12.6	29	6.6
Total	**270**	**100.0**	**166**	**100.0**	**436**	**100.0**

Past and Present Occupation

Like in the rest of Myanmar, agriculture was the main past occupation of 28.7% respondents (Table 4.17). Second largest group of 14.7% was unemployed, 13.1% were doing day labouring often termed as 'half-employed' and 12.9% were students. Only 8.5% were employed in the fishing and some others in the fishery related industries and sea-transport. The situation has changed considerably in Ranong as fishing is the main occupation of 29.4% of all respondents and agriculture dropped to a much lower ranking with only 3.2% of the respondents. This is because of the fact that Ranong has a sizeable fishing industry compared to its smaller agricultural base. Many Thai people do not like to work in fishing and thus the necessity of hiring migrants from Myanmar. Another group of 15.1% work in the fisheries related businesses such as fish sorting, cold storage, drying and packing of fish. The second largest group of 16.3% work in the domestic or retail businesses such as restaurant and entertainment businesses, shops and private houses.

Table 4.17: Past and Present Occupation

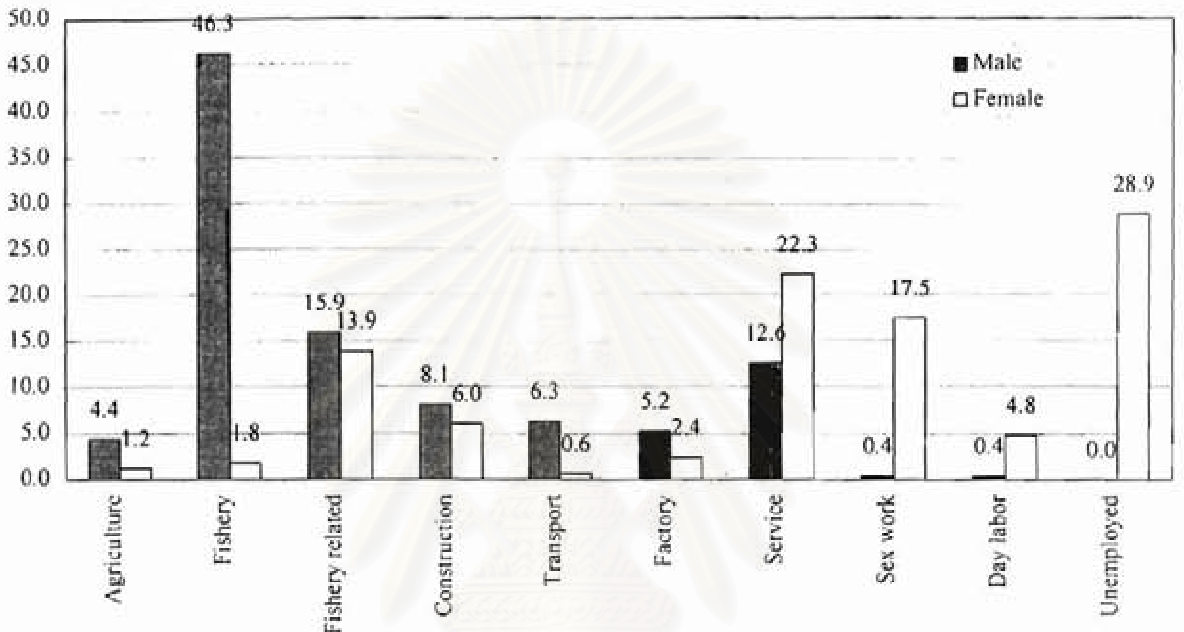
Past Occupations		
Occupations	**Frequency**	**%**
Agriculture	125	28.7
Fishing	37	8.5
Fishery Related	9	2.1
Sea Transport	10	2.3
Student	56	12.9
Construction	13	3.0
Factory worker	16	3.7
Service/maids	9	2.1
Day labouring	57	13.1
Others	39	9.0
Unemployed	64	14.7
Total	**435**	**100.0**

Present Occupations		
Occupations	**Frequency**	**%**
Agriculture	14	3.2
Fishing	128	29.4
Fishery Related	66	15.1
Sea Transport	18	4.1
Sex Worker	30	6.9
Construction	32	7.3
Factory worker	18	4.1
Service/maids	71	16.3
Day labouring	9	2.1
Others	2	0.5
Unemployed	48	11.0
Total	**436**	**100.0**

Eleven percent of the respondents claim to be unemployed at the time of the interview and all of them are women who are family members of the workers. This unemployed group constitutes 28.9% of all women respondents (Figure 4.2). Most of the women are employed

in the domestic service (22.3%), sex work (17.5%) and fishery related work (13.5%). Fishing is the main occupation of the men (46.3%), followed by fishery related work (15.9%) and the service industry (12.6%). Among fishermen, a majority of 59.4% are Burmese, 18.0% Mon and 11.8% Tavoy. Among sex workers 66.7% are Burmese, 10% Karen and the rest are Mon, Tavoy and other ethnic groups.

Figure 4.2: Present Occupation of Respondents by Gender



Thai Language Proficiency

Thai language proficiency is an important criteria to determine the migrants ability to communicate and interact with Thai employers, fellow workers and the local population. Without Thai language ability the migrants often face problems in getting information or assistance from Thai people. They also face difficulties in seeking health services at the Thai hospital and clinics. Only 14.7% of the respondents speak moderate to good Thai (Table 4.18) which often makes it difficult for the majority to communicate with their Thai employers, co-workers and law enforcing authorities. Despite their long years of living in Thailand (Table 4.21), almost nobody reads or writes Thai. This is quite different from the Laotians and Cambodians living along the borders of Thailand, with many having better Thai language proficiency.

People in the age range of 21-40 years have slightly better language skills than their younger and older counterparts. Women have slightly better language skills then men because women often spend most of the time in the house which is close to the Thai community and have to deal with Thai people more often. Among ethnic groups, Mon speak better Thai than the Burmese and Tavoy people. Language ability significantly improves with the duration of stay in Thailand especially among those living in Thailand for more than three years. There is no significant difference of language ability among various education groups. However people who have higher incomes have better Thai language ability than those with low

income or in other words, those with better Thai language skills are paid better than those with low language skills.

Table 4.18: Thai Language Proficiency of the Respondents (in %)

Proficiency level	**Read**	**Write**	**Speak**	**Listen**
Fluent/good	0.2	0.2	3.2	3.0
Moderate	0.2	0.5	11.5	15.1
Little	2.5	3.2	47.7	56.2
None	97.0	96.1	37.6	25.7
Total	**100.0**	**100.0**	**100.0**	**100.0**

In summary, most of the migrants are young people with a mean age of 27.5 years. Male to female ratio is 62:38. Just over half of the migrants are married and thus there is still a significant number of single people. There are more single men than women. Ethnically, Burmese are the dominant group followed by a much smaller number of Mon, Tavoy, Karen and others. Buddhism is the main religion with only a handful of Christians and Muslims. The literacy rate is quite good (93%) and 14% of the respondents completed over nine years of education. Changes in their past and present occupations have been very significant. In their new home in Thailand, they are trying to adapt to any job opportunities they are offered and as a result are often classified as unskilled workers. Better spoken Thai language is an advantage for the better paid jobs in Thailand.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

4.6 MIGRATORY EXPERIENCE

Places of Origin

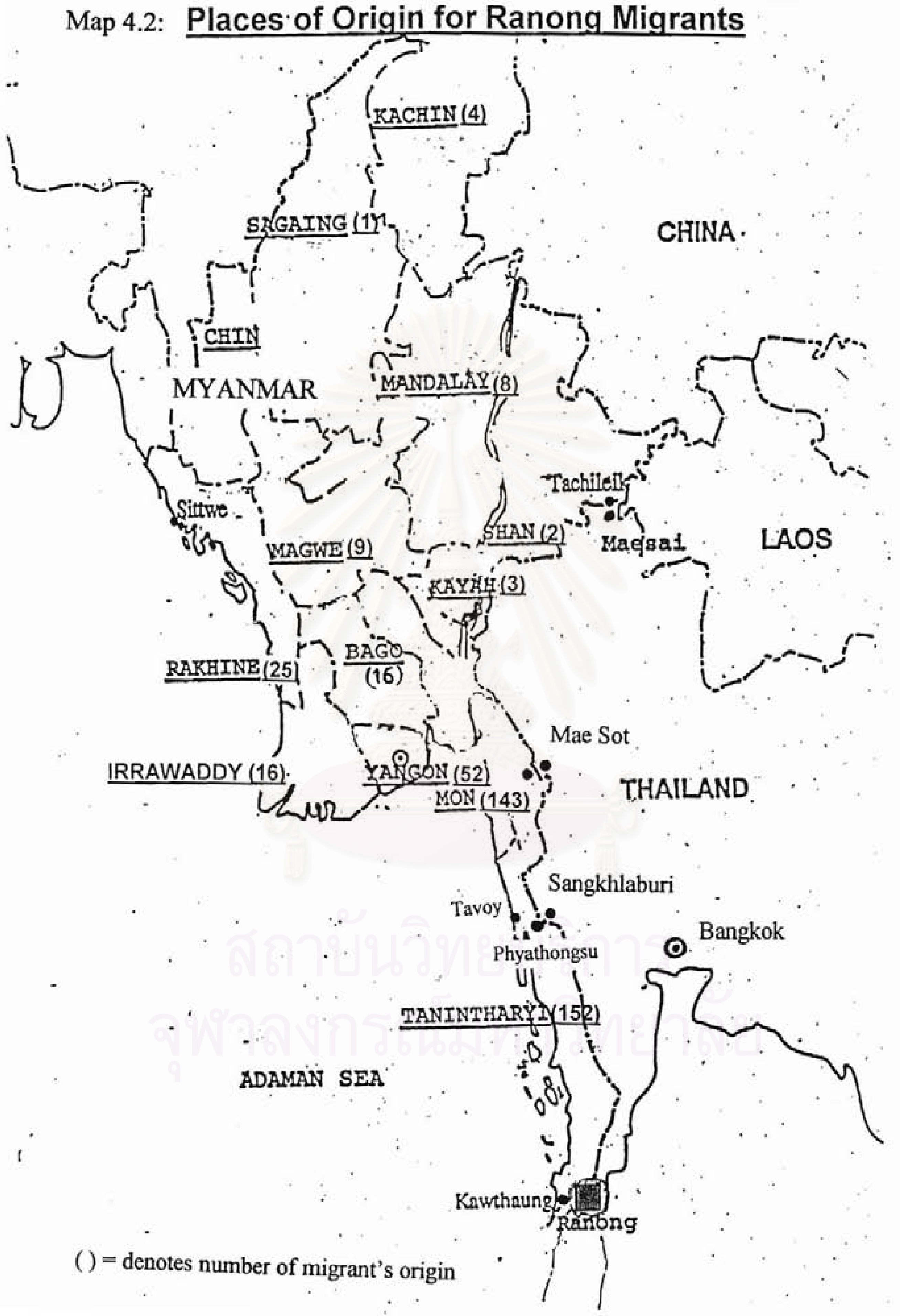
A great majority of the respondents have come from two main administrative areas of Myanmar, the Tanintharyi division (34.9%) and Mon State (32.8%) (Table 4.19) that are the two neighbouring areas of Myanmar with Ranong. Interestingly, 11.9% of the respondents have come all the way from Yangon and yet another 5.7% from Rakhine State bordering Bangladesh. Mon and Rakhine states (and other ethnic minority states) have a long history of ethnic conflicts and as a result many ethnic minorities have left home to seek refuge in Thailand and elsewhere. At present there are over 110,000 refugees in about a dozen of camps along the Thai-Myanmar border. Sometimes, the refugees and migrants are mixed together as they live in the same area and they have friends and relatives in the refugee camps and vice versa. However, there is no refugee camp in the close vicinity of Ranong.

Table 4.19: Places of Origin and Intended Places of Return

States/Divisions	Place of Origin		Place of Return	
Divisions	**No.**	**%**	**No.**	**%**
Bago	16	3.7	13	3.0
Irrawaddy	16	3.7	11	2.5
Magwe	9	2.1	6	1.4
Mandalay	8	1.8	7	1.6
Tanintharyi	152	34.9	135	31.0
Yangon	52	11.9	61	14.0
Sagaing	1	0.2	1	0.2
Sub-Total	**254**	**58.3**	**234**	**53.7**
States				
Kachin	4	0.9	5	1.1
Karen	3	0.7	3	0.7
Kayah	-	-	1	0.2
Mon	143	32.8	133	30.5
Rakhine	25	5.7	13	3.0
Shan	2	0.5	1	0.2
Sub-Total	**177**	**40.6**	**156**	**35.7**
Unknown/missing	5	1.5	25	5.7
Stay in Thailand	-	-	21	4.8
Total	**436**	**100.0**	**436**	**100.0**

** The main #Burmese state of Myanmar is divided into seven administrative divisions and the remaining areas of the country are divided into seven states according to the predominant ethnic minority groups in those areas.* You had **Burma**

Map 4.2: **Places of Origin for Ranong Migrants**



( ) = denotes number of migrant's origin

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Intentions and Place of Return to Myanmar

A great majority or 95.2% of the respondents intend to return to Myanmar in due course and this cuts across people from all areas of the country including Mon State (Table 4.19). There is no significant difference in the intended destination of return in Myanmar with that of their place of origin. Only 4.8% of the respondents intend to stay in Thailand which is much different from Sangkhlaburi where about two-thirds (64.4%) of the migrants do not intend to return to Myanmar. This is because of the fact that many of the migrants in Sangkhlaburi belong to ethnic minority groups (Mon and Karen) and there is no clear sign of an end of ethnic conflict in their home states. They also find people and authorities in Sangkhlaburi as very receptive to those who arrived in Thailand before 1976. However, the Mon and other migrants in Ranong intend to return to their home because they do not find Ranong authorities as accommodating as they are in Sangkhlaburi. Among those who do not intend to return home, one half come from Rakhine State of whom most are Muslim. Because of the conflict with the Burmese authorities, many Muslims in this state are displaced over the last two decades and a large number of them have gone to neighbouring Bangladesh as refugees. Overall, most of the respondents want to earn and save some money to start their new life at home and do not intend to stay in Ranong for too long.

Reasons for Migration

Key informant interviews reveal that almost all respondents irrespective of their ethnicity and place of origin have come to work in Thailand. A smaller number of them have come to join their families (Table 4.20). Unlike Sangkhlaburi, very few people have come to Ranong because of war or forced conscription. Forced conscription or labour have often been cited by human right activists to be widespread in Myanmar, but is not found to be a major factor in this study. However, in-depth interviews with key informants show that a great majority came to Thailand because of a multitude of problems of socio-economic and political difficulties, not simply one or the other and the political system in the country is certainly making their life difficult.

Table 4.20: Reasons for Migration by Ethnicity

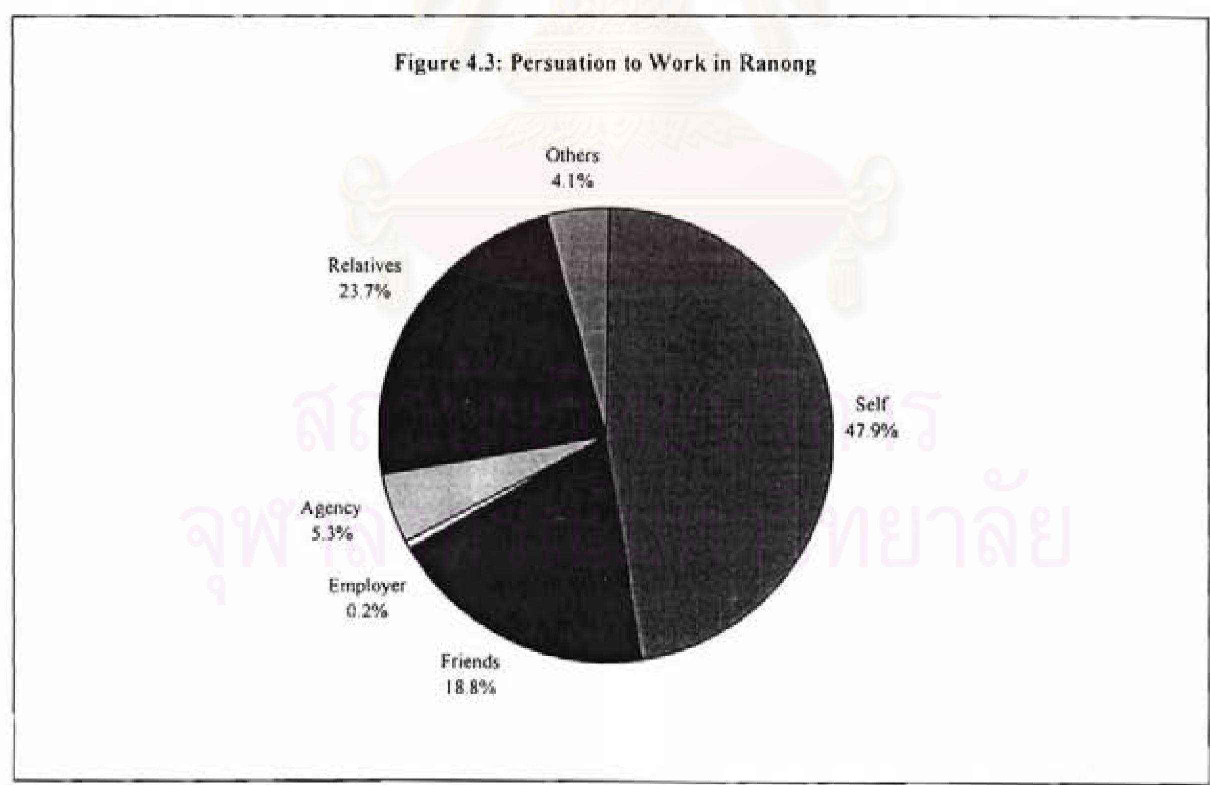
Reasons	Burmese	Mon	Tavoy	Karen	Others	Total
Seek Employment	90.4	95.0	92.2	95.7	100.0	92.4
Join Family	6.0	2.5	2.2	-	-	4.4
Escape Conscription	0.8	2.2	-	0.8	-	0.5
Other Reasons	2.8	2.5	3.9	4.3	-	2.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Rural farmers have been severely affected by the deteriorating economic situation in Myanmar. All farmers are required by state regulation to sell to the government a certain amount of their rice crop calculated on the basis of acres of rice field that they cultivate. When the rice production falls short of the required quota they are obligated to buy rice from the open market and resell it to the authorities at a much lower price. In these circumstances, their meagre income which usually is just adequate for their own survival, drastically reduces. In addition, people from the Mon State are subject to a variety of taxes imposed by the local military. All of these factors have worsened the already precarious situation which

makes their lives in Myanmar very difficult. To prevent political unrest, the government has closed all universities in Myanmar. So the students have nothing much to do after completing their school education. There are not many jobs in the production and private sectors. The people have a very limited choice for their livelihood in the country. The multitude of many of these "push factors" coupled with some "pull factors" in Thailand such as better income and livelihood encourage migration out of Myanmar.

Prior Knowledge of Conditions in Thailand

A majority of 70% of the respondents did not know about the Thai legal status, work conditions, and living situations before coming to Thailand. Those who knew about it received the information from friends (17.7%) and relatives (4.4%). Even then they really did not get the "real picture" of Thailand such as the current economic turmoil, police and immigration crackdowns, physical and sexual abuse, and the nature of exploitation by employers. Most of the prospective migrants did not openly talk about their impending departure because they were afraid of arrest and/or extortion by the authorities Although more than half of the respondents (59%) had many people in their villages who had worked in Thailand they were often too afraid to consult them. When contacted, these returnees did not, however, give an accurate account of the actual situation in Thailand, perhaps because they were too ashamed to tell what had actually happened to them. They were more interested to talk about the "good things" and "show-off" the fortunes they earned in Thailand. This is probably the reason why so many people are still migrating despite numerous reports of raids, arrests, abuses and tortures in Thailand.



The situation is quite different if the migrants want to go to the destinations inside Thailand such as Bangkok, Samut Sakhorn, Samut Prakan, Phuket, Songkhla etc. for higher paid jobs.

The same is true for those travelling to Malaysia and Singapore. They must find agents in order not to be caught by immigration and border police who control all the major roads leading to the south and central Thailand. The majority of agents are based in Ranong but a few have floating sub-agents in Kawthaung.

The agents operating through these routes work in close collaboration with border police who are responsible for the "safe passage" from Ranong to the southern and central parts of Thailand. The agents often offer two kinds of services - (i) arrange a trip from Ranong to the intended destinations and (ii) act as a recruitment agent for some employers. Different rates are charged by the agencies for each of these services which are shared with the police and other authorities. Overall, these travel and recruitment agents wield a great power on the migrants which becomes a source of conflict between them. There are also several reported cases of conflict and fighting among the agents who compete for the control of their business.

Routes of Migration

Kawthaung is the southernmost point of Myanmar and is the main port on the opposite side of Ranong. Almost all migrants pass through this port before entering Ranong. Exceptions to this could be some fishermen hired elsewhere in Myanmar who went straight to Ranong. Some migrants may have entered Thailand through another border crossing (e.g. Sangkhlaburi) and then moved to Ranong over land. Sometimes, some migrants arrested and detained elsewhere in Thailand are taken to Ranong for deportation.

Road communication between Kawthaung and the central part of Myanmar is passable during summer but often gets cut off during the rainy season. So most of the people tend to travel during the dry season to take advantage of the better road conditions. There are boats and ships from various ports from the central region to Kawthaung. Many people especially fishermen travel by this route. There is an airport in Kawthaung. This is an expensive option for a few rich. Overall, road transport remains the main mode of transportation.

How They Cross Border

Ranong-Kawthaung is a sea-border crossing located in the delta of Kraburi river. It takes about 30-40 minutes for a motorised boat to cross the about four kilometre long water way. There are immigration offices on both sides of the border which is open to Thai and Myanmar nationals. Foreigners are not usually allowed to cross even with a passport and visa, but special arrangements can be made for local visits only. Usually all migrants use this sea-crossing to enter Ranong.

Figure 4.4 shows that a great majority of 72.4% of the respondents have gone through both Thai and Myanmar immigration procedures and another 9.4% passed through Thai immigration only but not the Myanmar immigration, and 16.1% have not gone through any immigration procedure. Most of those who do not pass through immigration are recurrent visitors who know some special passage and procedure to by-pass the normal manoeuvre.

Expenses to Cross Border

Less than half or 41.5% of the respondents have paid a 101-500 baht fee to cross the border (Figure 4.5). Another 22.7% have paid 501-1,000 baht and 19.7% paid more than 1,000 baht. Only 7.8% claim to have paid nothing at all for the passage. This payment includes the cost

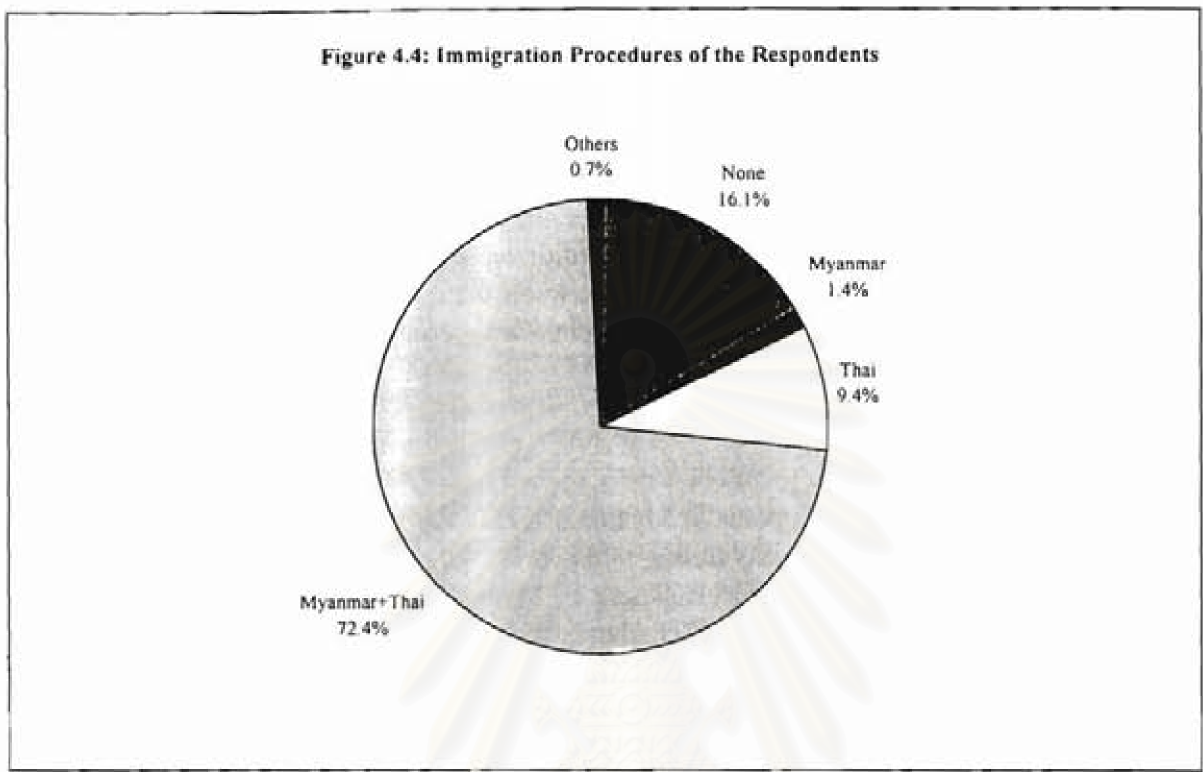
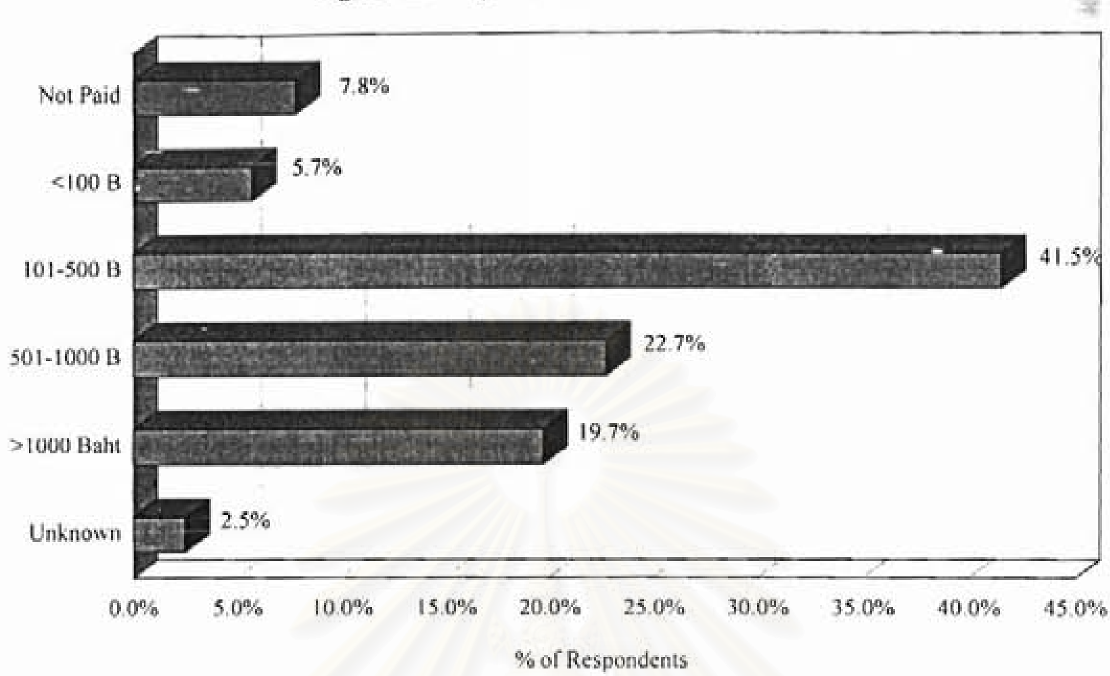


Figure 4.4: Immigration Procedures of the Respondents

for the boat trip (30 baht) and immigration fee in Thailand and Myanmar (50 baht each). It also includes any additional fee for the agent involved in the process.

Figure 4.5: Expenses Paid to Cross Border



Valid Document

Respondents were asked what kind of valid travel or immigration documents they possessed. There are three main groups of people - 36% have immigration cards, 31.9% have work permits and 27.1% have no documents (Figure 4.6). Surprisingly, 53% of the female migrants have no valid documents compared to only 11.1% of their male counterparts. Only 9.6% of the women have immigration cards compared to 52.2% of the men. This is because of the fact that most of the female sex workers and housewives (referred as unemployed) do not have any legal documents. Very few respondents in the agriculture sector have valid documents but a very high proportion of fishermen (82.2%) have immigration cards. Workers in the fishery related and service sectors tend to have work permits. Among ethnic groups, Tavoy people are more likely not to have valid documents. As expected, people with a higher level of education have valid documents (90%) compared to only 53.3% of those with no formal education. The presence of a valid document especially that of a work permit is very important for stable living and working conditions in Thailand. It also helps to ensure better health care in Thai hospitals and health centres.

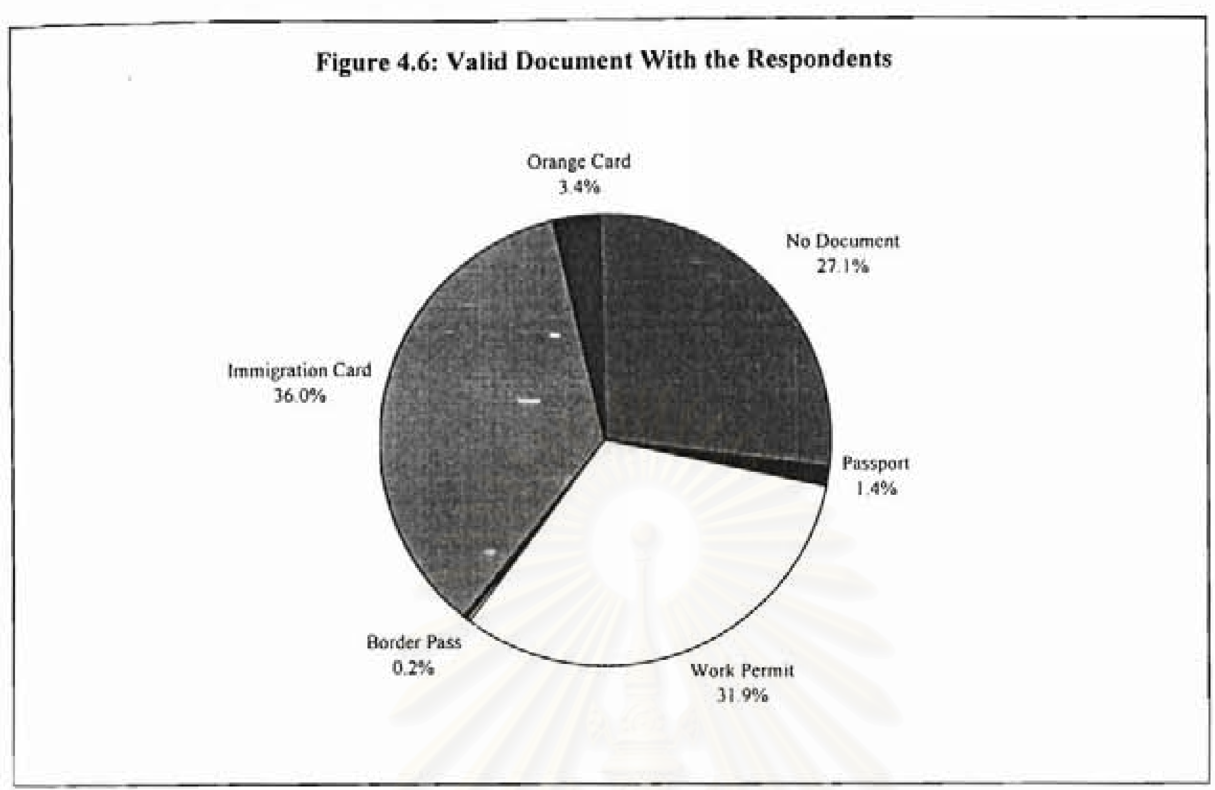


Figure 4.6: Valid Document With the Respondents

Recruitment Process

There are three different groups of migrants in Ranong. Those who wish to work in Ranong and its surrounding areas are usually arranged locally and earnings may not be very attractive. Second, those who want to go to work in southern and central parts of Thailand. These are more risky in terms of breaking immigration regulations and need initial investment for travel and recruiting agents but offers higher incomes. Third, which is not very common, is to travel to Malaysia and Singapore for a very attractive income but often associated with harsh punishment for illegal entry. Sometimes these three groups overlap each other i.e. people first come and work in Ranong and at the same time seek opportunities for higher paid jobs elsewhere in Thailand or Malaysia and Singapore. There is no clear pattern of the selection of these three groups. It usually depends on contacts with friends and relatives at the destinations as well as the initial investment one is able to make for the journey. All structured interviews were taken in Ranong and it therefore reflects the responses from the first group only.

When asked about who introduced them to come and work in Thailand, a great majority (47.9%) of the respondents claimed that they found out by themselves and another smaller segment said that they got help from their relatives (23.7%) and friends (18.8%). Only 5.3% stated that they had taken help from the recruitment agents in their place of origin. This may be true as it is very difficult for any agency to organise such trips in a country where the authorities are strongly opposed (at least in the public statement) to any departure and migration out of the country. Most of the people, however, form groups to travel together for their safety. This is especially true for the migrant women who often travel with male relatives or friends. Overall, there is no organised system of recruitment inside Myanmar and the flow of migration is arranged individually and sometimes with like minded people. This

is an important piece of information that shows how difficult it will be to organise any pre-departure program, which is often recommended as a precautionary measure for many migrant situations.

Migrants usually do not need any recruiting agents to cross the sea-border from Kawthaung to Ranong. Thus many of the migrants simply travel back and forth between Ranong and Kawthaung. Finding a job in Ranong is also a matter of personal contacts with the prospective employers, often through a friend or relative. However, there are some informal agents operating in Ranong who help the migrants to get a job and charge for the services.

Destination of the Migrant Population

A great majority of the respondents lived and worked in Ranong which is evident from the fact that 48.8% of them had been staying for over three years (Table 4.21). There are several thousand migrant workers in Thailand. Many of them, especially those working in the southern and central region of the country pass through Ranong (see above). In addition, several thousand Burmese migrants go to Malaysia and Singapore, and some of them are believed to have passed through Ranong. In fact, working outside Ranong provides a higher income and it is therefore more attractive to the prospective migrants to do so.

According to local sources, the number of migrants entering Ranong has dropped in recent months. There are three main reasons for the decline:

- Economic slowdown in Thailand has resulted in job loss in certain occupational groups notably in the construction and service sector but also in some production industries. There are fewer job opportunities now than a couple of years ago.
- The Thai government is revising its policies for foreign migrants and is encouraging the employers to hire Thai workers by replacing the foreigners. This has resulted in the loss of jobs for the migrants.
- Stringent law enforcement by the Thai immigration and police to suppress illegal migrants has also made trafficking from the border to the central provinces more difficult. This has resulted in a further reduction of illegal migrants in the area.

Duration of Stay in Thailand

About half of the respondents (48.8%) have worked and lived in Thailand for more than three years and 27.4% have stayed over five years (Table 4.21). This is a significantly long time in a foreign country and deserves careful analysis of the migrants' livelihood here. Only a smaller segment of 19.1% have worked in Thailand for less than a year. As expected, older people have worked for a longer duration compared to the younger. There is no correlation with the gender and education level of the respondents. There is also no significant correlation with occupation but agriculture, service and sex workers tend to stay for a shorter duration compared to the migrants working in fishing and fishery related jobs. This might be due to the longer commitment from the employers as well as the higher income. In terms of level of income, those who are staying longer than three years have a significantly higher income than those who are staying less than three years.

Table 4.21: Length of Stay by Ethnicity

Duration of Stay	Burmese	Mon	Tavoy	Karen	Others	Total
0 to 11 months	20.3	15.0	29.4	-	16.7	19.1
1 to 3 years	33.5	26.3	37.3	43.5	20.0	32.2
4 to 5 years	20.7	23.8	17.6	30.4	20.0	21.4
Over 5 years	25.5	35.0	15.7	26.1	43.3	27.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Places of Living

Table 4.22 shows that 44.5% of the respondents live in the Myanmar community in Ranong which is a home for the majority of the fishermen (90.6%) and less so for other occupational groups. Labour houses are the usual places of living for many occupational groups such as agriculture (64.3%), fishery related (63.6%), construction (90.0%), water transport (72.2%), factory (83.3%) and service (52.1%). More than half, 58.3% of the unemployed, most of whom are the family members, also stay in labour houses. Almost one third, 31.0% of the domestic service workers and 35.7% of the sex workers, live with the employers, while 20.1% of the female workers live with their employer compared to only 1.1% of their male counterparts. A significant number of them are below 20 years old. This raises an important question about the safety and security of these girls because they are perceived as potential partners by many of the men. Overall, there are more younger people who live in the Burmese community while the majority of the older people stay in labour houses provided by their employers. Finally, people with higher income live in the Burmese community showing a preference for the familiar surrounding. Lower income groups live in the labour houses.

Table 4.22: Place of Living of the Respondents

Occupation of Respondents	Place of Stay					
	With Employer	Labour House	Thai Comm.	Burma Comm.	Others	Total
Agriculture	7.1	64.3	21.4	7.1	-	100.0
Fishing	-	1.6	2.3	90.6	5.5	100.0
Fishery Related	1.5	63.6	4.5	25.8	4.5	100.0
Construction	-	90.6	3.1	6.3	-	100.0
Sea Transport	-	72.2	-	16.7	11.1	100.0
Factory	11.1	83.3	-	5.6	-	100.0
Service	31.0	52.1	1.4	15.5	-	100.0
Sex Worker	35.7	21.4	3.6	25.0	14.3	100.0
Labour	-	33.3	-	66.7	-	100.0
Unemployed	-	37.5	2.1	58.3	2.1	100.0
Others	-	50.0	-	50.0	-	100.0
Total	8.3	40.3	3.0	44.5	3.9	100.0

Living With Whom

Table 4.23 shows that 34.8% of the respondents live with their nuclear family and another 20.5% with their compound family and/or relatives. Traders tend to stay alone or with their friends more than any other group. A significantly high proportion of 36.1% live with friends, 27.8% of whom live with the same gender. There is a significant age difference among those who stay alone. Most of the older people stay with their nuclear family and some with their compound family whereas most of the younger people stay with friends and/or their compound family. There is no significant gender difference in the living circumstances; with the exception of sex workers, women tend to live in a family rather than with friends. There is a significant correlation between the duration of stay and the living circumstances. People who are staying for more than three years tend to live with their nuclear and compound family whereas those who are staying for less than three years tend to live with friends and sometimes in a compound family.

Among various occupational groups, agricultural workers live with nuclear or compound families, but most of the fishermen live with friends and sometimes with compound families. Those who work in the fishery related jobs or construction industry often live with their nuclear family. Many young men and women who work in the service sector choose to live

Table 4.23: Living Circumstances by Ethnicity

Living With	Burmese	Mon	Tavoy	Karen	Others	Total
Stay alone	8.4	6.3	7.8	13.0	6.7	8.1
Nuclear family	34.8	46.3	31.4	21.7	20.0	34.8
Compound family	20.0	17.5	29.4	26.1	13.3	20.5
Friend (f, m or both)	36.8	30.1	31.3	39.1	60.0	36.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

with friends. The presence of family members serves as an important "social control" over people's sexual behaviour especially for those who live outside of wedlock or who are separated from their "partners". As many young respondents live with friends, they often develop relationships and this is part of the sexual networking in the community.

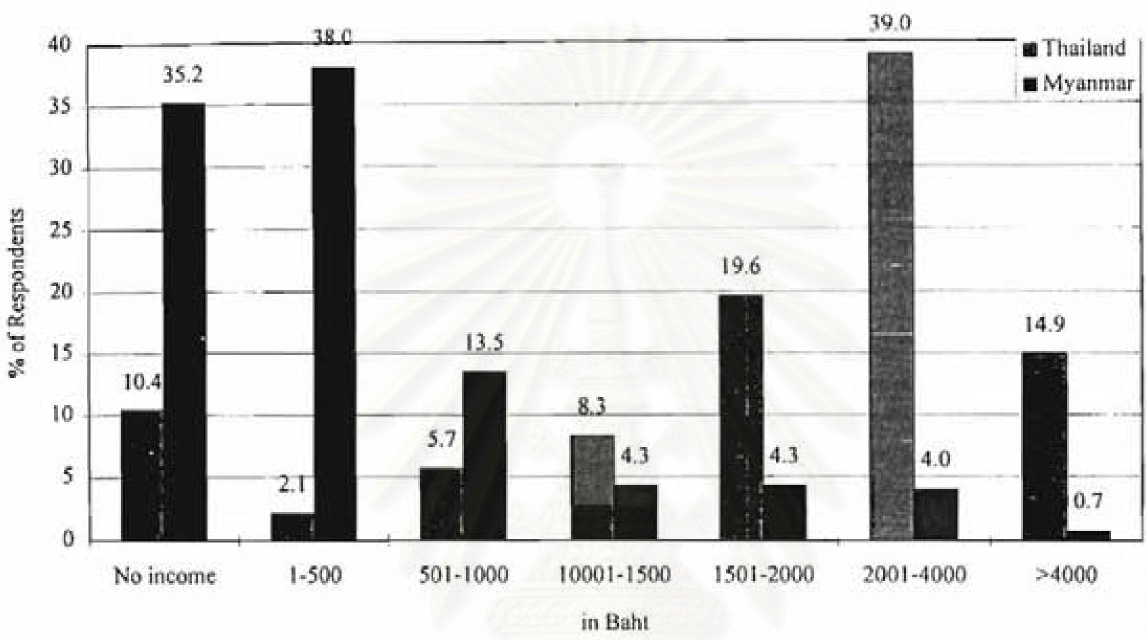
Income, Savings and Disposable Cash

There is a significant income level gap between Myanmar and Thailand. The mean monthly income in Myanmar is 492 baht compared to 3,075 baht in Thailand. However, one must take the purchasing power parity into consideration as the costs of living are very different in these two countries. In Thailand, the migrants have to pay for almost everything such as housing, water, electricity and food whereas in Myanmar they usually live in their family house and pay very little for water or electricity. The percentage of unemployed respondents was 35.2% in Myanmar, and of those who had a job most were earning less than 500 baht a month (Figure 4.7). In Thailand, most of the respondents are earning between 500 and 4,000 baht a month. This level of income explains why undocumented migrant workers are coming to Thailand despite difficult working conditions, widespread abuse and exploitation due to their illegal status.

As expected, very young (less than 20 years old) and older (more than 40 years old) people are earning less than the 21-40 years old age groups. This is because of the fact that most of

the jobs migrants do are labour intensive and demand physical fitness. It is also found that those with secondary or higher education earn much more than those with only primary or no formal education. Among ethnic groups, Burmese earn the most followed by the Mon and Tavoy people. This is related to the education level and working skills of the respondents. In terms of duration of stay, those who spent more than three years in Thailand earn significantly better than those who stayed less than three years. This is because the migrants need to learn some basic Thai and also have to get acquainted with the Thai working

Figure 4.7: Monthly Income in Myanmar and Thailand



conditions before they can get a decent paying job. The situation is probably quite different for the sex workers who earn more when they are young and new in Thailand. They have the highest income among all occupational groups; 79% of them earning more than 4,000 baht a month. Those working in fishing and agriculture sector have a better income than the ones who work in the service sector or temporary labouring.

Taking the daily minimum wage of 130 baht in Ranong as a measurement to illustrate the low income level of migrants, it is found that most of the migrants earn about 60-70 baht. This is probably the most crucial factor why Thai employers continue to hire cheap migrant workers instead of regular Thai labourers. Despite the apparent higher income in Thailand, 61.1% of the respondents claimed that they are not able to save enough money. Unstable or temporary job conditions are cited as the main reason followed by high costs of living in Thailand. Only 13.6% of the respondents were able to save more than 5,000 baht a year. Most of them keep money with themselves while only a few leave their money with the employers or others.

The majority of 66.1% of the respondents never sent money to Myanmar and the rest sent some money to their parents and relatives. This significantly low remittance is due to the presence of the nuclear and/or extended family. The situation might be different for people who are leaving alone to work in central Thailand.

Rest and Recreation

In addition to the living conditions, rest and recreation are considered to be important factors that influence the migrant and population behaviour. Especially that relevant to the increased HIV/AIDS vulnerability such as alcohol, drug and substance abuse, and sexual networking including visiting sex workers. Loneliness and boredom are often cited as the main reasons for such activities although peer pressure remains the dominant force in many instances.

Watching television is the main entertainment for most of the respondents (28.4%) (Table 4.24). Another 19.6% of the respondents spent their leisure time by meeting friends and relatives in the area, which is true for most of the occupational groups. Games and sports are cited by 15.9% of the respondents, which is slightly more favoured by the younger people than those over 40 years of age. And yet 10.4% of the respondents stay at home to spend their leisure time. Drinking alcohol or visiting entertainment places is not very popular, perhaps because of the high cost attached to such activities. On occasions, a large number of the fishermen and other young people drink alcohol and drunken behaviour is not that uncommon within the migrant community. At least some of these same drunken people visit entertainment places and sex workers. Fishing companies often offer a "special group bonus" for the crew members of a returning boat that include drinking and visiting sex workers. As this is a group bonus, individual members are not allowed to take away their share for something else but follow the group to avail the opportunity for free.

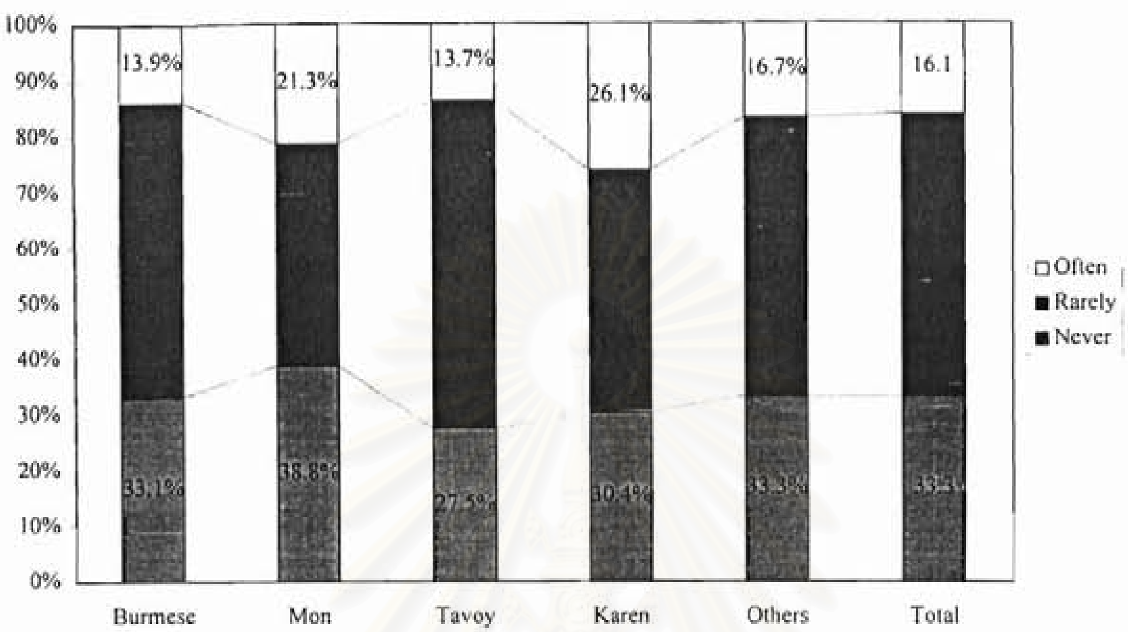
Among ethnic groups, Tavoy people like to stay home, whereas Burmese and Mon are more inclined to drinking. As expected, male respondents like sports and other outdoor activities and women prefer to watch television. People with a higher income like to go to entertainment places and those with low or no income stay home. It should be mentioned here that many young men and women work in entertainment places, and can unintentionally get involved in high risk behaviour with their customers or fellow workers. This is a common way of getting involved in indirect sex work, which is very common in Ranong at present following the closure of most of the established brothels in 1994-95.

Table 4.24: Rest and Recreation by Age Groups

Rest and Recreation	Age Groups of the Respondents				
	<21 yrs	21 - 30	31 - 40	> 40 yrs	Total
Stay home	11.2	7.4	12.5	21.9	10.4
Games and sports	21.4	14.0	19.3	3.1	15.9
Watch television	23.5	27.4	31.8	40.6	28.4
Meet relatives	19.4	24.2	13.6	9.4	19.6
Drink alcohol	4.1	7.4	4.5	6.3	6.0
Watch video	5.1	3.7	2.3	6.3	3.9
Go to tea shop	5.1	4.2	1.1	12.5	4.4
Entertainment etc	2.0	1.9	-	-	1.4
Others	8.2	9.8	14.8	-	9.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Community Activities

Figure 4.8: Participation in Community Activities by Ethnicity



Community activities in this predominantly Buddhist community often entail temple and religious ceremonies. People join in together during these occasions to raise funds for the monks and temples. Figure 4.8 shows that 16.1% of the respondents often participated in community activities, another 50.6% rarely did so, and 33.3% of the respondents never participated in any community activities. There is no significant difference among ethnic groups although Karen and Mon are more likely to participate in the community activities compared to the Burmese and Tavoy. There is no significant difference between men and women or their marital status. However, older people are more likely to go to these community activities than the younger ones. People who stayed longer in Thailand are more likely to participate in these activities compared to the new arrivals. It is also true that people who speak better Thai to join in with the Thai people and community for these religious activities. Interestingly, fishermen and fishery related workers participated in community activities more than those in the agriculture and day labouring sector.

Community activities in this low socio-economic setting are the indication of people's collaboration, for their own affairs and religious leaders often play a crucial role in promoting these activities. These community activities and gatherings may be an important strategy for the community-based HIV/AIDS prevention programmes as well as for the care of people with HIV/AIDS and other social issues.

Visit Home in Myanmar

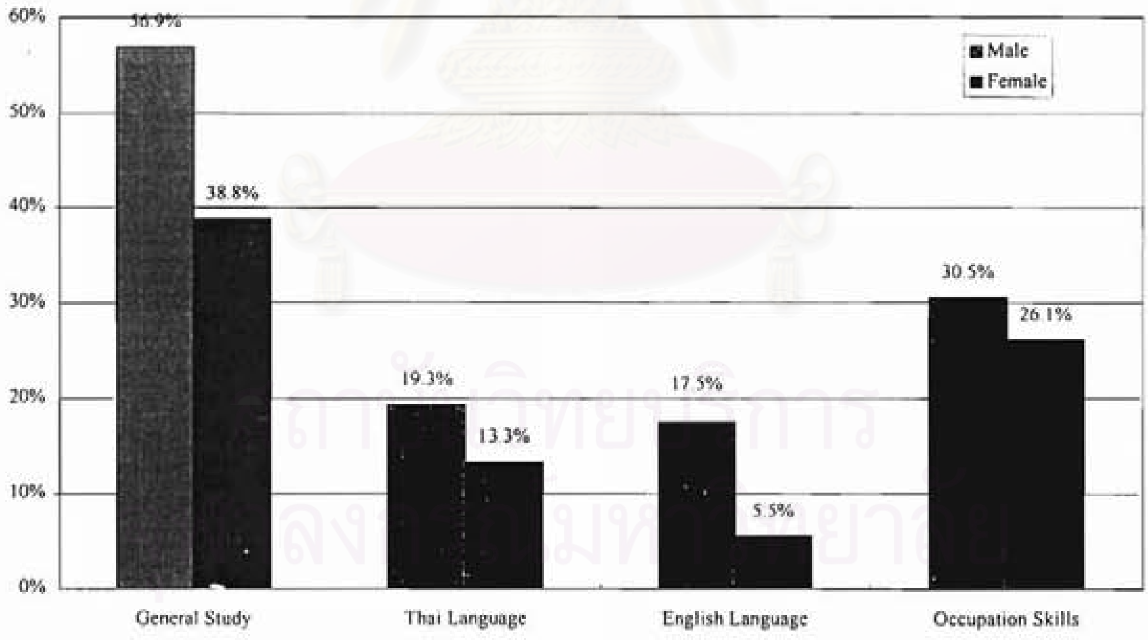
An overwhelming 66.7% of the respondents never visited home since they came to Thailand. Only 24.3% visited home during the last year, 7.8% during the last two to five years. Visiting home is not one of their priorities as many of them have their nuclear and compound families with them. Respondents claim that it is difficult and expensive for them to travel

back home by road especially for those who come from the distant areas of the country. Another reason for not visiting Myanmar is the non existing job security. They are not sure if they will get back their job once they leave it for some time. They are therefore more concerned with their new life in Thailand and the improvement of their living conditions. However, if they are given a choice, many of them would like to visit home regularly to keep in touch with their families and friends way back home.

Looking to the Future

Economic hardship and lack of job opportunities in Myanmar are the main reasons for a great many of the migrants to come to Thailand. If they can save more money, most of them would like to support their families and relatives in Myanmar to relieve their difficult situations. In a multiple choice questions a great majority expressed interest in various forms of studies and training if they were only able to afford to do so (Figure 4.9). Most of them are interested in general studies, followed by occupational as well as Thai and English language training. As expected, women showed less interest in these further studies as most of them are from a rural background and therefore lack basic education. Younger people showed more interest for general academic education and English language training whereas middle aged people are interested in occupational and Thai language training. In general, Burmese and Karen are more interested in studies than the Tavoy and Mon.

Figure 4.9: Choice of Future Education and Training



Unlike Sangkhlaburi where 62.5% of the respondents plan to continue living in Thailand, a great majority (90.1%) of the Ranong respondents intend to return to their home in Myanmar. Only 7.4% have any intention to live in Thailand and a few would in fact like to go to a third country if possible. There are few interesting reasons behind these decision making processes. First, Burmese and Tavoy (ethnic southern Burmese) form a large bulk (69.4%) of the migrant population in Ranong who have a historical differences with Thai people. They usually do not speak Thai and in fact, are not keen to learn any Thai. They are

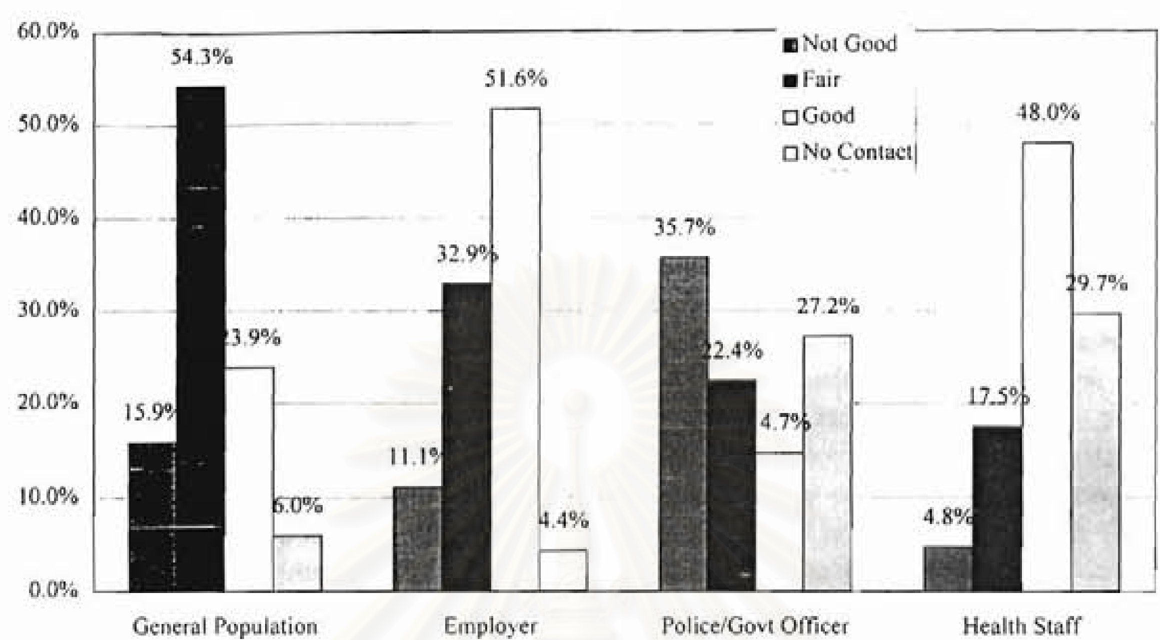
therefore not so interested in living in Thailand forever. Mon and Karen who have closer ethnic and cultural ties with the Thais are more interested to live in Thailand. This issue has been highlighted in the Sangkhlaburi section of the report. Second, unlike Sangkhlaburi, Ranong province has never been a favoured place for permanent migration. The people and authorities in Ranong are accommodating the migrants for economic reasons. They do not have a policy or an administrative support system to allow permanent migration. Local and immigration authorities in Ranong are carefully controlling the migrant situation in the province. In Sangkhlaburi, migration of ethnic Karen and Mon has been a regular phenomenon for several decades and the authorities continue to naturalise them into Thai society. As a result, many Burmese migrants there have friends and relatives who have become a Thai national. However, if the Thai government revises its policy in Ranong and allows migrants permanent settlement, then at least some more migrants will be interested to stay and live in Thailand.

Attitude Towards Thai People, Employers and Officials

In general, migrant people have a love and hate relationship with the local population. The migrants need the local people to secure their jobs and incomes, and yet they have to face many difficulties and at times even abusive treatment from the local people, employers and law enforcing authorities. Similarly, the employers and local people need migrants for their economic advantage but they also dislike some of their attitudes and behaviour. Respondents were asked to express their opinion about the general Thai population, employers, health officials, police and government officials. The responses are mixed. Only 14.7% have rated police and government officials as good compared to 51.6% of the employers, 48.0% of the health staff and 23.9% of the general population (Figure 4.10). Police and the government authorities have received the highest rate of disapproval as 35.7% rated them as not good compared to only 4.8% of the health staff, 11.1% of the employers and 15.9% of the general population.

There is no surprise in these findings as police and immigration officials control the movement of the migrants. Because of the migrants illegal status, the authorities often have to take unpopular actions against them. Sometimes they arrest the migrants for illegal entry into the country or impose a fine for illegal employment. They also deport the migrants across the border to Myanmar. In addition to their job related encounters with the migrants, the police and immigration officials are often blamed for the ill treatment of the detained and/or arrested migrants. There are numerous reports about physical and sexual abuses of migrants by the police which results in a strong disliking for them. On the other hand some employers and health officials are more understanding with the migrants and provide support and services as required.

Figure 4.10: Attitude Towards Thai Authorities and People



More male respondents like their employers than their female counterparts because women often work in the domestic services, sex and entertainment businesses where they receive less good treatment. Women also do not speak Thai as good as their male counterpart, which makes it difficult for them to communicate with their Thai employer. There is no significant difference among gender groups about their attitude towards the general Thai population and police force. However, women like Thai health officials much more than men do, and in fact they visit hospitals and clinics more often for their own health care as well as for the care of their children. Among the various age groups, older people like Thai health officials much more than the younger groups. Only 52% of those 20 years or younger visited hospitals compared to 88% of the 40 years or older people.

Ethnicity has some correlation with the attitude towards Thais. More Burmese and Tavoy people dislike Thais than Mon and Karen. This again reflects the history that the latter two ethnic groups have better relations with Thailand and many of their people have migrated and permanently settled in parts of Thailand. On the other hand, the Burmese had fought several wars with the Thais and some people may still harbour some disdain. There is a correlation with the level of education of the migrants. The respondents who speak better Thai rate the general Thai people higher as well as employers and health officials. However, speaking Thai does not change their attitude towards Thai police and immigration officials who are unanimously disliked across gender, age, ethnicity, education and occupational groups.

In summary, most of the migrants in Ranong have come from the neighbouring areas of Myanmar i.e. Tanintharyi division and Mon State. Reasons for their migration are complex and constitute various social, political and economic hardship they are experiencing in their country. Before coming to Thailand, many of them did not have a clear knowledge about the conditions in Thailand. In most instances, they made their own decisions about migrating to

Thailand supported by some information from their friends and relatives as there is no organised travel or recruiting agent. About two-thirds of the migrants have either an immigration card or a work permit with them and they have paid about 800 baht to cross the border, which comprises the immigration fees, transport and other related expenses. About half of the respondents have lived in Thailand for more than three years and this is more common among Mon and Karen than among the Burmese and Tavoy people. Most of the migrants live in very poor living conditions, sometimes provided by their employers. Usually migrants prefer to live in one of the several Burmese communities in town. Although the physical conditions in these communities are no better than those provided by their employers, they find it more comfortable to live among their own people and families. Just over half of the respondents live with their nuclear or compound families, another 36% live with friends and some 8% stay alone. The latter two groups are often young single men with only a few women among them. Because of their long stay in Thailand and reasonably good income, most of the migrants especially younger people have developed some or other form of entertainment in their community. Watching television, meeting friends playing games and sports are the common ways to spend their leisure time. Many migrants also join in various forms of temple and other community activities often in their own community but also with their Thai neighbours. These community activities help them to develop their sense of pride and dignity, and at the same time build closer interactions with the local people. In general, most of the migrants have a rather good attitude towards the general Thai population, their employers and health officials but most of the migrants strongly dislike Thai police and immigration officials. A great majority of migrants never visited home since they came to Thailand but they intend to return home after some time. They still maintain close contacts with their families and friends at home and plan to return to their place of origin. Only a few intend to live in Thailand permanently.

STUDY FINDINGS ON HIV/AIDS RISK SITUATIONS

This section covers the knowledge, attitude and practices relevant to HIV/AIDS in the study location. It addresses the basic questions of 'ever heard about AIDS' and 'ever heard of STDs', examines knowledge and misperceptions of HIV transmission, the symptoms and cure of HIV/AIDS, and testing methods. It further elaborates on the knowledge and myths of HIV prevention, their specific risk behaviours, attitude towards people living with HIV/AIDS (PWHAs), and finally includes a self-assessment of their HIV/AIDS vulnerability. The variables from the demographic information and the migratory experiences are systematically tested to find out the significant relevance and correlation among them.

4.7 KNOWLEDGE AND AWARENESS OF HIV/AIDS/STD

Design and Methods of Analysis

Altogether the following five aspects of HIV/AIDS knowledge are chosen for systematic analysis. The first two deals with single questions (1 & 2) about symptoms and cure of HIV/AIDS. The other three are number of questions grouped together (3, 4 and 5). In addition to usual frequencies and cross-tabulations, the latter three groups of questions (3, 4 & 5) have also used a scoring method (see Chapter I) which allowed for comparing means through the one-way ANOVA. The five areas of knowledge questions are as follows:

Knowledge on symptoms, testing and cure of HIV/AIDS

1. Do people with HIV/AIDS have to have symptoms?
2. Can AIDS be cured?
3. Two questions on methods of HIV testing;
   Six questions on signs and symptoms of HIV/AIDS;

Knowledge and misperceptions of transmission

4. Eight questions on modes of HIV transmission;
   Six questions on misperceptions of transmission;

Knowledge of HIV prevention

5. One question on the prevention of HIV by use of condom;
   Five questions on the myths and misconceptions of HIV/AIDS prevention;

As indicated above, demographic and migratory experience variables in the previous two sections are systematically analysed against all five areas of questions. Some of the large and sometimes unrelated sub-groups of questions are analysed separately before performing the total group analysis. For example, in the "knowledge and misperception of transmission", the combined large group of 14 questions is broken down into two sub-groups - one sub-group of eight questions on the "mode of transmission" and another sub-group of six questions on "misperceptions of transmission". This has allowed a better understanding of the actual

situation, whether the overall knowledge is influenced by a lack of knowledge or misperceptions about transmission or both.

Further analyses are made about people's responses towards sexual behaviour and acceptable norms, as well as some of the masculine behaviour relevant to HIV risk situations. Analyses are also done on the specific risk behaviours and prevention practices such as alcohol and injecting drugs and substance use, unsafe sex practices including commercial sex, and blood transfusions. A short paragraph is given on the respondent's self assessment of HIV vulnerability. Last but not least, an analysis is given on the respondent's attitude towards people living with HIV/AIDS (PWHAs) which has become an important social, economic and political issue as the epidemic is growing and the number of AIDS cases are increasing all over the region.

Ever Heard of AIDS: Through What Means?

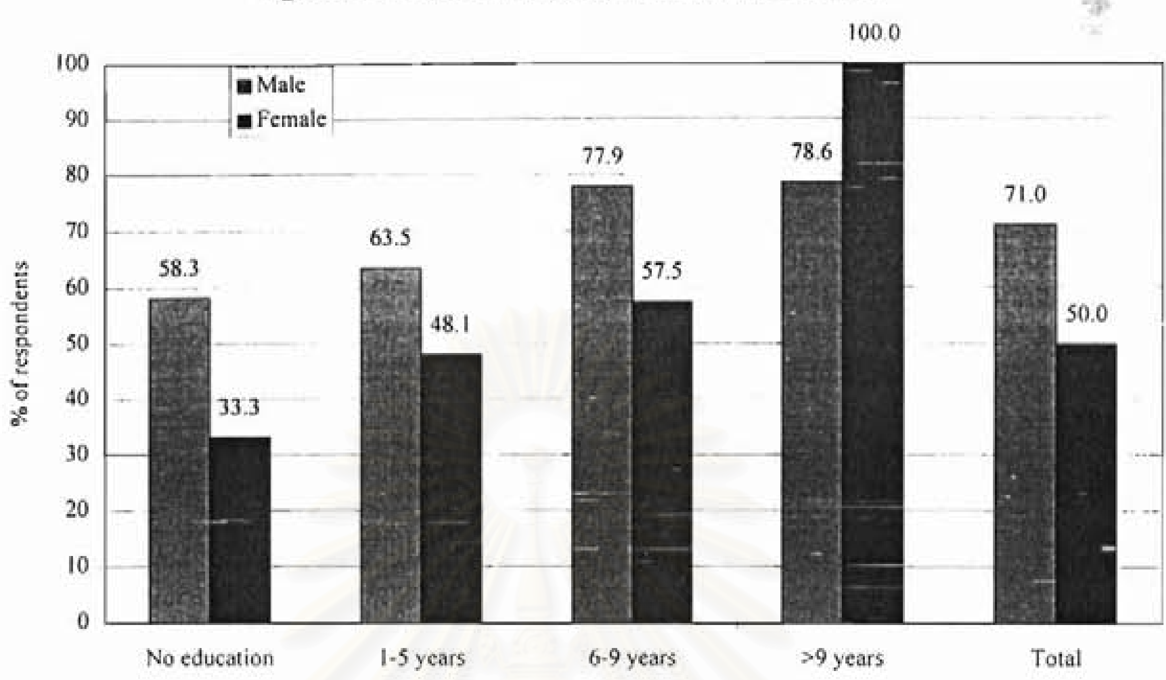
The respondents were asked if they had ever heard about HIV/AIDS and if so, where and how? Before coming to Thailand, 63.0% had heard about AIDS in Myanmar (Table 4.25). There, however, has been an increased awareness of up to 94.5% of respondents after they have come to Thailand. Overall, 97.0% of the respondents had heard about AIDS either in Myanmar or Thailand, and 60.5% have heard about it in both countries. This apparent low level of response in Myanmar only is due to the fact that many migrants came to Thailand several years ago and have not returned home since. Several years ago HIV/AIDS awareness in Myanmar was not as active as it is today. Thus, they have learned about the disease in Ranong or elsewhere in Thailand. Overall, only 3.0% of people did not hear about AIDS neither in Thailand, nor Myanmar or both countries. This appears to be an overall good figure compared to the situation in many other rural areas in Myanmar or even in Thailand.

Table 4.25: Heard About AIDS in Myanmar and Thailand

		THAILAND		
		No	**Yes**	**Total**
MYANMAR (BURMA)	**No**	3.0	34.0	37.0
	Yes	2.5	60.5	63.0
	Total	5.5	94.5	100.0

Fewer women, 50% knew about AIDS in Myanmar compared to 71% of men (Figure 4.11). Among both men and women those who had a higher education showed a higher knowledge of AIDS. There is no significant difference among the ethnic groups or Thai language comprehension. In Thailand, there was no correlation with age, gender, marital status, education, ethnicity among those who heard of AIDS. The key informant sources from the qualitative information reveal that people are learning about the disease over time. As it is a new problem in the area and people usually do not get much information from the Thai media, they still do not understand the disease quite well.

Figure 4.11: Heard of AIDS by Education and Gender



When asked how they heard about AIDS, most of the people have responded that they did by talking to someone else in either Thailand or Myanmar (Table 4.26). While it is an encouraging signal that people are actually talking about AIDS, the content of information might have serious problems; a fact which is reflected in the data on perceptions and misperceptions about the disease (see below). Despite wide ranging coverage about HIV/AIDS on Thai television and radio, only about a quarter of the respondents received this message from the media. Many of the respondents do not have access to TV, and they also do not understand Thai well. Some poster and billboards are appearing and up to 47.0% of the respondents claimed to have noticed some of the messages in Thailand compared to about 25% in Myanmar. Similarly, they also heard more of AIDS from the health officials and NGO staff in Thailand compared to a much smaller proportion in Myanmar. It should be mentioned here that World Vision, an NGO, has a HIV/AIDS programme in the area for more than five years and many of their staff and volunteers are in fact Burmese.

Table 4.26: How Did They Hear About AIDS

Through What Means?*	In Myanmar (N=274)	In Thailand (N=412)
Talking to people	45.5	77.5
Television/radio	23.2	22.9
Newspapers	24.1	33.0
Posters/billboard	24.8	47.0
Health officials	13.6	22.5
Teachers/school	6.9	0.7
NGO workers	1.8	10.8
Total	63.0	94.5

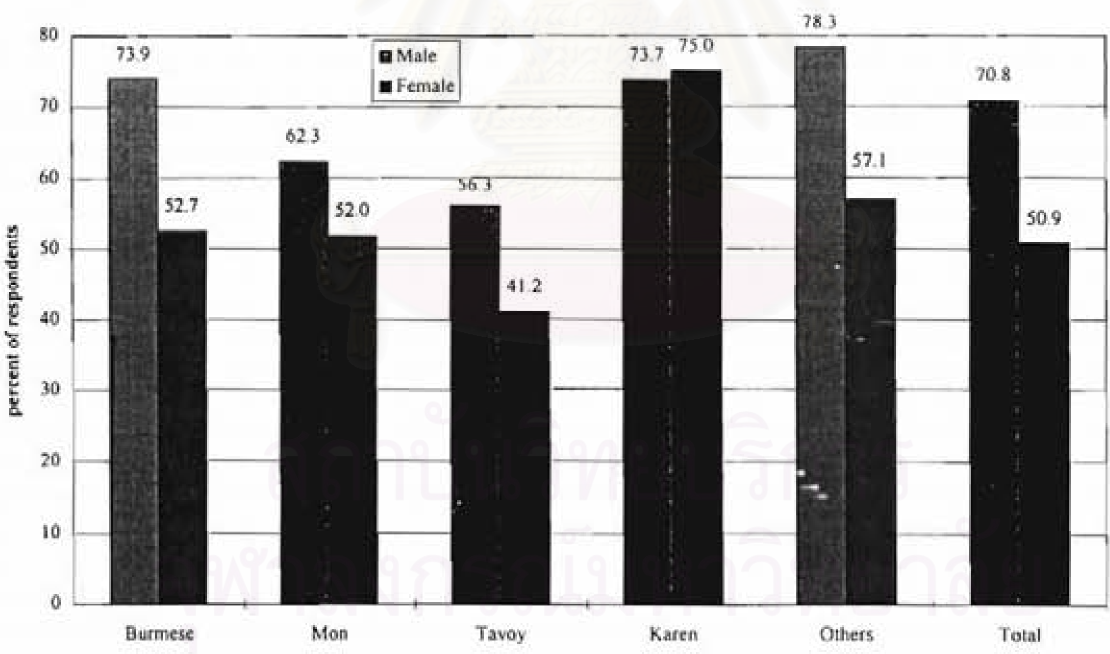
** multiple answers allowed;*

Heard of STDs - Through What Means?

STDs are known to be very closely linked to HIV transmission. It is therefore very important to gauze the knowledge of STDs for the HIV/AIDS risk situation. A modest 63% of the respondents have heard about STD either in Thailand or Myanmar, or both. This is much lower than the 97% who had heard about AIDS. One explanation for that fact is that people know about individual STDs such as gonorrhoea or syphilis, but not so much about STDs as a group of diseases. Secondly, discussion about sex and sex organ related illnesses are a taboo in much of this rural population. So people often identify the disease by some symptoms. Another possible reason is the low prevalence of STDs in the community and therefore not much public health attention is given to this situation.

A significantly low number of women (50.9%) has heard of STDs compared to 70.8% of men (Figure 4.12) but with no significant difference in their marital status. People who have a higher education know much more about STDs than people with no formal education. Among ethnic groups, Karen and Burmese have more knowledge than the Tavoy and Mon. Younger people have less knowledge than the older as they probably have not yet suffered from STDs.

Figure 4.12: Heard of STDs by Ethinicity and Gender



Knowledge of HIV Transmission

More than three-quarters of the respondents chose the correct answer for the three main modes of HIV transmission, i.e. heterosexual intercourse (77.5%), sharing needles for injection (89.9%) and receiving blood transfusions (76.6%) (Table 4.27). There are varying responses for other less common modes of transmission such as anal or oral sex, deep kissing or sharing blood stained razors and knives. There are a number of "not sure" answers

about modes of transmission which signify uncertainty in the mind of people. All of the results point to the fact that at least some of the respondents have not received reliable HIV information mainly by talking to others.

Table 4.27: Knowledge of HIV Transmission

Possible Transmission by	Agree	Disagree	Don't know	Total
Heterosexual intercourse	77.5	5.5	17.0	100.0
Homosexual intercourse (man to man)	64.0	3.0	33.0	100.0
Anal sex (man to woman)	59.2	4.4	36.5	100.0
Oral sex (man or woman)	48.6	15.1	36.2	100.0
Deep kiss (mixed with saliva)	25.2	46.8	28.0	100.0
Receiving blood transfusion	76.6	6.7	16.7	100.0
Sharing needle for injection	89.9	1.8	8.3	100.0
Sharing (blood stained) razor/knives	80.5	4.1	15.4	100.0

Misperception of HIV Transmission

Despite the relatively good knowledge about the main modes of transmission, misperceptions are abundant among the respondents (Table 4.28). This ranges from 56.5% believing that mosquito bites transmit HIV to 35.2% believing that sharing a toilet or a bathroom would transmit HIV. Yet another 41.1% claim that HIV could be transmitted by sharing clothes and 35.8% have identified eating and drinking with HIV-positive people as a mode of transmission. A good number of 27.1% of the respondents believe that HIV could be transmitted by simply touching the PWHAs. A quarter of the respondents is still "not sure" about the modes of transmission which again signifies a high degree of uncertainty. Only a smaller proportion of respondents disagrees with the casual modes of transmission of HIV/AIDS.

Table 4.28: Misperception of HIV Transmission

Possible Transmission by	Agree	Disagree	Don't know	Total
Touching PWHAs	27.1	48.2	24.8	100.0
Sharing eating and drinking	35.8	41.7	22.5	100.0
Sharing toilet/bathroom	35.2	40.0	24.8	100.0
Sharing clothes	41.1	38.9	20.0	100.0
Mosquito or insect bites	56.5	22.6	21.0	100.0

The mean score of the above transmission modes are analysed by demographic and migratory experience variables by using the one-way ANOVA. There is no significant difference between various age groups, religion, Thai language proficiency or duration of stay in Thailand. Men have a slightly better knowledge than women. Divorcees have a better knowledge about HIV transmission than married people. Among the ethnic groups, the Mon have less knowledge than the Burmese. No significant difference exists among the different religious groups but Buddhists have more misunderstandings than Christians. People with

six to nine years of education have better knowledge than those with no formal primary education (1-5 years). However, people with high school or higher education did not show any significant difference to those without education. Among various occupational groups sex workers have a better understanding about HIV transmission than almost all other occupational groups such as agriculture, fishery related, sea transport, construction, factory, service and unemployed people. This is because of the fact that the NGO working in this community is consistently providing education and preventive services to the sex workers. Fishermen and fishery related workers have the second and third highest scores but not so significantly different from other groups except construction workers who scored the lowest among all groups. Those with an income level higher than 4,000 baht a month have better knowledge than those earning 500-1000 baht a month. It should be mentioned here that the sex workers earn much more than the others and many of them fall in the uppermost income bracket.

It should be emphasised that many of the misunderstandings and discrimination against PWHAs originate in the misperceptions about the modes of HIV transmission. It is therefore of the utmost importance that an HIV/AIDS prevention and care project raises awareness about these misperceptions with an equal strength as to the modes of transmission. The projects could also actively promote its target audience that casual contacts with PWHAs do no cause any harm. These forms of educational projects are expected to help build an enabling environment for the care and support of the PWHAs.

In summary, the overall knowledge of HIV transmission had no correlation with age, gender, religion, spoken Thai and duration of stay in Thailand. There was, however, a significant difference between two main ethnic groups, i.e. that Burmese have a better knowledge of modes of transmission than Mon. There also is a significantly better knowledge among respondents who had six to nine years of education and those without any formal education or primary education. Finally, among various occupational groups, sex workers have better knowledge than all other groups. However, fishermen and fishery related workers have better knowledge than construction workers who scored lowest among all.

Knowledge of Symptoms, Testing and Cure

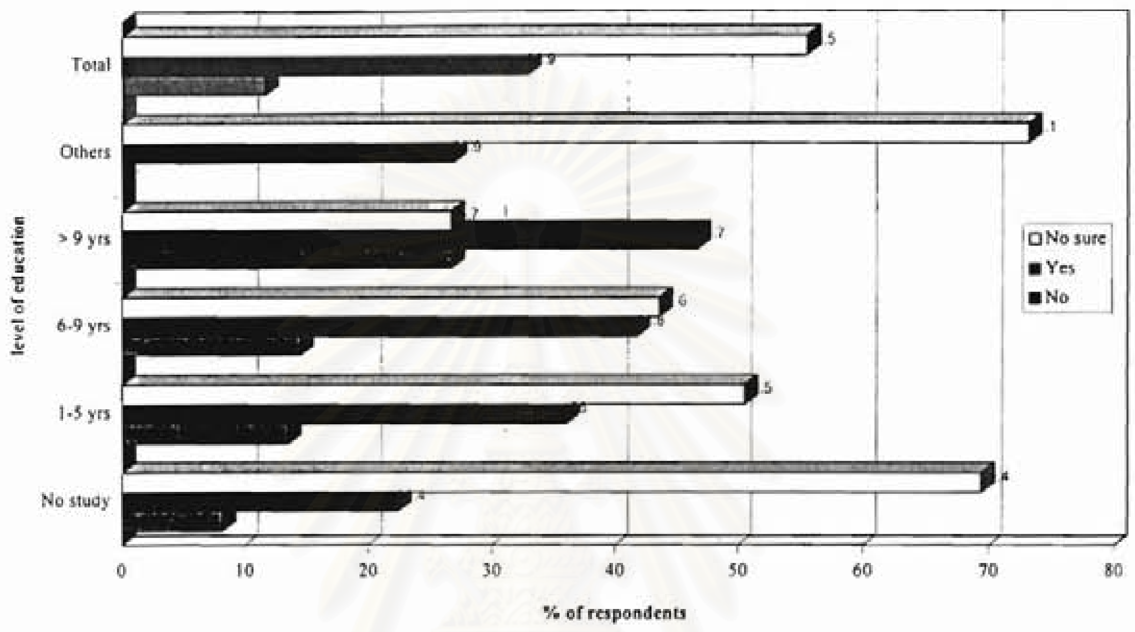
In this section, respondents were asked two critical questions about "if HIV-positive people could have no symptom" and "if there is a cure for AIDS". Their responses are analysed by simple frequencies and cross-tabulations. At the same time, eight other questions about respondents' knowledge about HIV/AIDS symptoms, HIV testing and treatment are analysed by the one-way ANOVA against demographic and migratory experience variables.

Knowledge of HIV/AIDS Symptoms

Respondents were asked if some people with HIV/AIDS could have no symptoms. A marginally high proportion of 46.2% agreed and 11.7% disagreed. Another large proportion of 42.1% are unsure about it (Figure 4.13). The nature of the disease with its long incubation period of eight to ten years keeps the disease "out of sight" of many and might be an explanation for the above responses. Once again, the nature of the disease is one of the key information that HIV/AIDS projects should emphasise on.

Figure 4.13 also shows that people with 1,000 baht or more monthly income have better knowledge than those with less income. Naturally, the latter group also has slightly more 'not sure' answers than the former group. There is a significant difference among gender, marital status, age groups, level of education, ethnic groups, place of origin and Thai language proficiency.

Figure 4.13: HIV/AIDS Patients Could Have No Symptom



Those who lived in Thailand for more than five years have a slightly better knowledge than those who stayed for less than one year. This is because of the fact that the new arrivals have not received enough information in Myanmar and have not yet had access to the information sources in Thailand. Among various occupational groups, sex workers have the highest number of correct answers and only a few 'not sure' responses (Table 29). Fishermen,

Table 4.29: HIV-Positive People Could Have No Symptom

Occupation	Yes	No	Don't know	Total
Agriculture	28.6	7.1	64.3	100.0
Fishing	56.3	13.3	30.5	100.0
Fishery Related	40.9	4.5	54.5	100.0
Construction	31.3	15.6	53.1	100.0
Sea Transport	50.0	16.7	33.3	100.0
Factory workers	22.2	11.1	66.7	100.0
Service workers	46.5	9.9	43.7	100.0
Sex workers	66.7	23.3	10.0	100.0
Day Labourers	33.3	22.2	44.4	100.0
Unemployed	37.5	8.3	54.2	100.0
Others	50.0	0.0	50.0	100.0
Total	**46.1**	**11.7**	**42.2**	**100.0**

fishery related and sea-transport workers also have a good number of correct answers but they still have a high proportion of 'not sure' answers which reveals a certain degree of uncertainty. Agriculture, construction and factory workers present a very high number of incorrect and not sure answers. These groups appear to be less informed about almost every aspect of HIV/AIDS and perhaps, are not yet reached by the existing HIV/AIDS programmes.

The respondents were asked what they thought the possible symptoms of AIDS could be in a multiple choice questionnaire. A majority of them know about two common symptoms of AIDS, i.e. loss of weight and skin infections but only about half gave other correct answers about symptoms of HIV/AIDS (Table 4.29). Still a very significant proportion of "not sure" answers indicates a great degree of confusion about the disease.

The mean of the scores of these answers are analysed against demographic and migratory experience by one-way ANOVA. There is no significant correlation with age, religion, duration of stay and Thai language proficiency. However, male respondents have slightly better knowledge than females and also Christians score slightly better than Buddhists. Among ethnic groups, the Burmese have a significantly better knowledge than the Mon. Divorcees have very significantly better scores than the single and married people. For the level of education, people who had six to nine years of education were fare better than those with primary education. In general, the higher education level provides higher levels of knowledge. Among the occupational groups, the sex workers have a significantly better knowledge than most of the other groups e.g. agriculture, fishing, fish related, construction, factory, service and unemployed. Also fishermen and fish related workers have better scores than the factory, construction and service workers. Finally, people whose income is more than 4,000 baht a month have better knowledge than the lower income groups.

Table 4.30: Knowledge of Symptoms of HIV/AIDS

Symptoms	Yes	No	Don't know	Total
Looks thin, loose weight	76.1	5.0	18.8	100.0
Skin infections	66.5	3.4	30.0	100.0
Fungal infection in the mouth	47.2	2.8	50.0	100.0
Chronic diarrhoea	59.4	4.6	36.0	100.0
Chronic cough	56.3	4.1	39.5	100.0
Chronic fever	56.4	5.7	37.8	100.0

Knowledge of Methods of HIV Testing

The questions about HIV testing methods which usually require a relatively high level of knowledge have been used to gauge the depth of general knowledge of HIV/AIDS. A large majority, 81%, answered the question correctly that blood testing is the right method for HIV diagnosis and only 1.6% gave the wrong answer (Table 4.31). A relatively smaller proportion of 17.4% of the respondents are "not sure" whether blood tests are used for HIV testing. This is simply a reflection of an overall ignorance about this relatively new disease and its prevention. When asked if urine tests could diagnose HIV, 38.6% of respondents have agreed and another 44.4% are "not sure".

Table 4.31: Knowledge of Tests for HIV Diagnosis

Testing Methods	Yes	No	Don't know	Total
Blood test	81.0	1.6	17.4	100.0
Urine test	38.6	17.0	44.4	100.0

Cure for HIV/AIDS

The respondents were asked if there is a cure for AIDS, and 12.8% have answered "yes" and 63.1% "no", while yet another 24.1% are not sure or do not know the right answer (Figure 4.14). There appears to be a constant problem of misunderstanding about AIDS treatment. While the media and some AIDS workers continue to place high hopes on the "ARV cocktail therapy", many local and indigenous groups emphasise the "exciting" value of some herbal and traditional therapies. These different approaches have created a mixed situation of hopes and desperation in the mind of people especially those suffering from AIDS. If we consider that none of these therapies provide 'real cure' for the disease, then these responses are quite satisfactory.

Figure 4.14: Knowledge of Cure for AIDS by Education

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

In general, male respondents have a slightly better knowledge than females; excluding female sex workers who have a very high level of knowledge. In general, women have a significantly low level of understanding. Those over 40 years of age have a significantly lower knowledge than other age groups. This might be due to their lower level of education and less access to information sources as most of women work in certain occupations such as agriculture, construction or day labouring. Respondents who had more than six years of education, scored significantly better than those with no formal and primary education. Among the occupational groups, sex workers have the highest number of correct answers. However, fishermen and sea-transport workers have good knowledge about a cure for AIDS.

There is a significant correlation with the knowledge of AIDS cure by ethnicity, religion, duration of stay in Thailand, Thai language proficiency and income.

Table 4.32: Knowledge of Cure for HIV/AIDS by Occupation

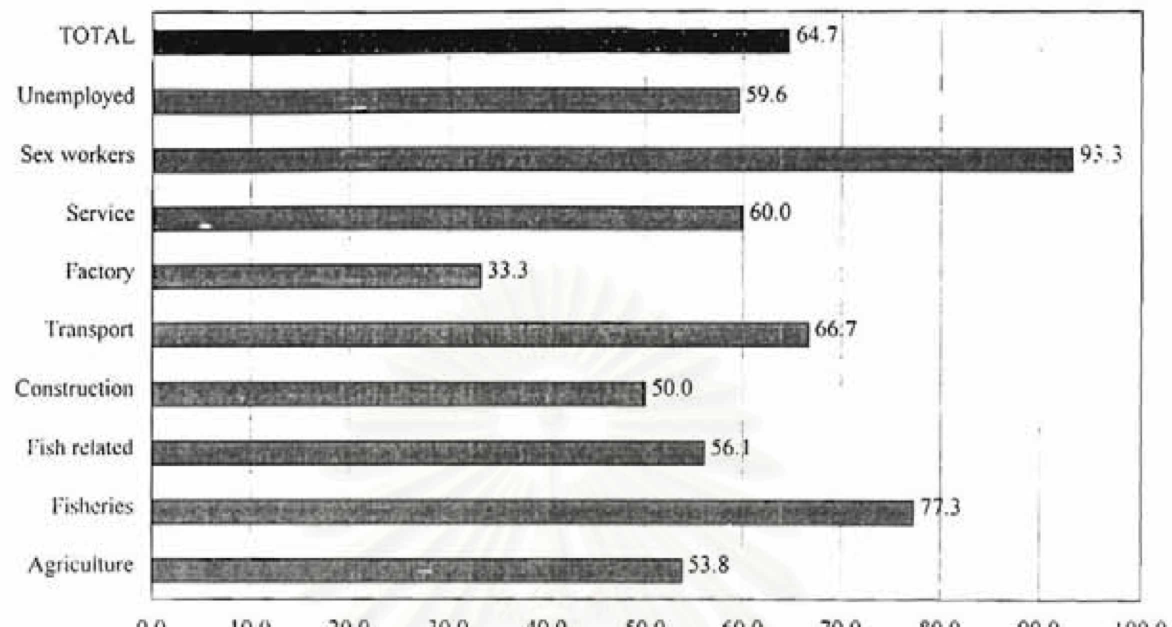
Occupation	Yes	No	Don't know	Total
Agriculture	28.6	35.7	35.7	100.0
Fishery	10.2	74.2	15.6	100.0
Fishery Related	15.2	62.1	22.7	100.0
Construction	18.8	50.0	31.3	100.0
Sea Transport	11.1	72.2	16.7	100.0
Factory	16.7	55.6	27.8	100.0
Service	9.9	56.3	33.8	100.0
CSW	13.3	83.3	3.3	100.0
Labour	22.2	66.7	11.1	100.0
Unemployed	10.4	47.9	41.7	100.0
Others	0.0	50.0	50.0	100.0
Total	**12.8**	**63.1**	**24.1**	**100.0**

In summary, the general knowledge of symptoms, testing and cure of HIV/AIDS has no significant correlation with age, gender, religion, ethnicity and the duration of stay in Thailand. There is no significant difference among education sub-groups but respondents who had more than nine years of education scored slightly better than all other groups, especially those without any formal education. Divorcees have a significantly better knowledge than single and married people. Among ethnic groups, Burmese have a consistently better knowledge than Mon. Among various occupational groups, sex workers have a significantly better understanding of HIV/AIDS than fishermen, fishery related, agriculture, construction, factory, service and unemployed workers. However, the fishermen also have better knowledge than the construction, service and factory workers.

Prevention of HIV/AIDS

Over 64% of the respondents agreed that condoms can prevent the sexual transmission of HIV. Only 8.3% of them have disagreed but 27.0% are not sure or do not know (Figure 4.15). It is possible that at least some of them have no idea about condoms as they never use them. Those with a higher education have a significantly better knowledge about condoms. Similarly, those who have an income i.e. over 4,000 baht per month, 85.7% think that condoms prevent HIV compared to 44.4% with less than 500 baht income. There is no significant difference among ethnic groups but 87.5% of the Christians acknowledge that condoms are used for prevention compared to 65.3% of the Buddhists and 45.5% of the Muslims. Overall, a significantly higher proportion of men (70.3%) agree that condoms prevent HIV compared to 55.5% of their female counterparts. Among occupational groups, sex workers have the best knowledge about condoms but many other groups also have a reasonable understanding. Factory workers in particular have a very low knowledge of condom use. There is no correlation with Thai language proficiency, duration of stay in Thailand and their place of origin.

Figure 4.15: Use of Condom Prevents HIV by Occupation



Misperceptions of HIV/AIDS Prevention

There are plenty of misperceptions that affect people's decision to take preventive measures for HIV transmission. Some of these misperceptions may directly or indirectly increase their HIV vulnerability. Respondents were asked several questions about some of the common misperceptions about HIV/AIDS prevention (Table 4.33). Once again, about a quarter of "not sure" answers show the great uncertainties of people. There are significant problems with the "misperception" that having sex with healthy partners could actually prevent HIV infection. Sex workers in Ranong often base their decision whether to use condoms or not on the healthy appearance of their clients. Over half of the respondents believe that getting tested for HIV every three months will keep them safe from a possible HIV infection. This is especially true for the sex workers and is considered to be one of the main reasons why they do not use condoms on a regular basis. Some fishermen and other clients of sex workers have the dangerous "misperception" that drinking alcohol before having sex with the sex workers will safeguard them of an HiV infection. So instead of using condoms they drink heavily before going to visit the sex workers and ignore their request to use condoms.

Table 4.33: Misperceptions of HIV/AIDS Prevention

Prevention Modes	Agree	Disagree	Don't know	Total
Having sex with healthy partners	18.2	55.9	26.0	100.0
Not use condom if partner is not a CSW	37.2	37.2	25.5	100.0
Not inject semen/sperm inside vagina	32.9	30.9	36.2	100.0
Drink alcohol before and after sex	7.6	59.8	32.6	100.0
HIV testing every three months	51.7	26.4	21.8	100.0

The mean scores of the answers in Table 4.33 are analysed against demographic and migratory experience by one-way ANOVA. These analyses show that there are no significant differences about these misperceptions among various age groups, religion, marital status, duration of stay in Thailand or Thai language ability. Women have more misunderstandings than men. Divorcees, most of whom are women, have a better knowledge than single and married people. Among ethnic groups, Burmese have a better understanding about these misperceptions than the Mon. However, Karen also have a better knowledge than the Mon. People with no formal education or primary education have significantly more misperceptions than those with six to nine years of formal education. Among various occupational groups, as was the case with other HIV/AIDS related knowledge, sex workers have a better knowledge than factory, service, agriculture, fishery related, construction, temporary labour and unemployed people. The fishermen who also have a good knowledge of HIV/AIDS, have a better understanding than the construction and factory workers. This analysis also illustrates that the higher income groups have a better knowledge about HIV prevention than the lower income groups.

Summary of HIV/AIDS Knowledge

Total knowledge of HIV/AIDS transmission, symptoms, testing, prevention and cure has been analysed against main occupation by one way ANOVA (Table 3.34). It indicates that the mean knowledge score of all respondents is 0.5241 out of possible 1.0 which is much higher than the mean score of 0.4054 of the study population in Sangkhlaburi. Sex workers have the highest score in Ranong (0.7724) followed by fishermen (0.6073). Construction, factory and agriculture workers have the lowest scores at 0.3331, 0.3619 and 0.3769 respectively. These total knowledge score will be a helpful guide in prioritising the target population for the intervention programme for the latter three groups who despite low prevalence of risk behaviour may still be vulnerable to HIV transmission.

Table 3.34: Total Knowledge of HIV/AIDS by Occupation

Descriptives

			N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
							Lower Bound	Upper Bound		
total kn score	main occupation	agriculture	14	.3769	.3134	8.376E-02	.1959	.5578	.00	.92
		fishing	128	.6073	.1956	1.729E-02	.5731	.6415	.10	1.00
		fishery related	66	.5299	.2310	2.843E-02	.4731	.5867	.03	.94
		construction	32	.3311	.2295	4.058E-02	.2483	.4139	.00	.81
		sea transport	18	.5467	.2081	4.905E-02	.4433	.6502	.20	.89
		factory	18	.3619	.2276	5.364E-02	.2487	.4751	.00	.70
		service	71	.4732	.2698	3.202E-02	.4093	.5370	.00	.98
		csw	30	.7724	.1306	2.384E-02	.7236	.8211	.52	1.00
		temporary labour	9	.4607	.2380	7.932E-02	.2778	.6436	.05	.73
		unemploy	48	.4497	.2736	3.948E-02	.3703	.5292	.00	.94
		others	2	.5373	.1381	9.762E-02	-.7031	1.7777	.44	.63
		Total	436	.5241	.2521	1.207E-02	.5004	.5478	.00	1.00

4.8 ATTITUDES AND BELIEFS OF SEXUAL BEHAVIOURS

Sexual Behaviour and Acceptable Norms

Culturally and socially acceptable sexual behaviour may vary from country to country and even within the sub-populations in a country. For example, many of the hill-tribe and ethnic minority populations in northern Thailand have a much more open attitude towards commercial and extramarital sex than those from the southern part of Thailand. However, it is very difficult to generalise what people think and what they actually do.

Respondents were asked the following questions concerning sexual behaviour and their acceptance in the community (Table 4.35). It reveals some predictable results as more men are approving pre-marital and extramarital sexual relations including commercial sex. Very few men and women approve of women having pre- and extra-marital sex.

Exactly 47% of men agree that single men can have sex with women who are not commercial sex workers compared to only 16.5% of the women. Almost similarly, 31.3% of the male respondents approve single men to have sex with sex workers compared to 16.3% of the women. Looking at the opposite, 40.7% of men approve single women to have sexual relations with men compared to only 11.3% of the women. These findings show the crucial gender differences in sexual behaviour of the study population, which is probably very common in many other countries in the region. It is partly because of these socially acceptable norms that the predominantly male mobile population avails the opportunities to develop sexual relationships in their adopted homes, or worse yet in terms of HIV transmission, they visit commercial sex venues. Migrant women may willingly or unwillingly become part of this sexual network, and in addition may become sex workers.

Table 4.35: Sexual Behaviour and Acceptable Norms

Sex Practices	Agree			Disagree			No opinion		
	M	F	Tot	M	F	Tot	M	F	Tot
Married man could visit commercial sex workers	20.2	1.3	14.4	76.5	96.3	82.5	3.3	2.5	3.0
Married man could have sex with other women (not a CSW)	21.9	3.8	16.3	72.7	91.3	78.3	5.5	5.0	5.3
Single man could visit commercial sex workers*	31.3	16.3	26.7	64.3	80.0	69.1	4.4	3.8	4.2
Single man could have sex with other women (not a CSW)*	47.0	16.3	37.6	47.5	71.3	54.8	5.5	12.5	7.6
Married woman could sex with other man (not husband)	7.7	3.8	6.5	89.6	95.0	91.3	2.7	1.3	2.3
Single woman could have sex with other man*	40.7	11.3	31.7	53.8	83.8	63.0	5.5	5.0	5.3

* there is a statistically significant difference between men and women;

Masculine Behaviour and Acceptability

Many traditions and cultures have their brand of masculine prowess and some of them could actually be harmful "misconceptions" leading to risk behaviour for HIV transmission. The following questions were asked concerning what is termed masculine behaviours (Table 4.36).

Kheun khrue or getting sexual experience with a "professional" woman before marriage has been a common practice in Thailand. Usually an eligible young Thai man would go for his first sexual experience with a woman, often a sex worker, before he will actually get married. In recent years, however, the significance of this traditional practice has lost its importance due to the AIDS epidemic. It is not quite clear if it is still a common practice in Myanmar. Over two-thirds (70.5%) of the respondents disapprove of this practice and only 18.7% agree with it. There are three questions about condom use. A slight majority of 58.2% of respondents disagree that the "man who does not use condoms during sex is brave". This represents a good general attitude. A proportion of 30.0% agrees that condoms reduce sexual feelings and gratification but 50.0% are not sure about it. It is quite possible that many of those in the "not sure" group have not had any practical experience with condoms as its overall use among the population is very low. The last question asked about condom use reveals disregard or suggest unfaithfulness on behalf of the partner who suggests condom use. This is a common problem in many cultures and even in spite of an extensive HIV/AIDS campaign this attitude has not changed much. Just about half of the respondents agrees with this. In fact, this is one of the main reasons why a large number of women are becoming infected by their male partners who contracted the disease through casual unsafe sex. "Fung muk" which is referred to as the injection of oil or the insertion of marble under the skin of the penis is a popular practice among certain population groups such as fishermen. A good 21.1% agreed that "Fung muk" increases sexual gratification, and in fact, during interviews at least 20 or 7.4% of the respondents claimed to have practised it themselves.

Table 4.36: Masculine Behaviour and Acceptability

Masculine Practices	Agree	Disagree	Don't know	Total
Single man should have *kheun khru* (get sexual experience) before marriage	18.7	70.5	10.8	100.0
Man who do not use condom during sex are brave	17.9	58.2	23.9	100.0
Using condom during sex reduces sexual feelings and gratification	30.0	20.0	50.0	100.0
Drinking alcohol before and after increases sex potentials	23.2	31.2	45.6	100.0
Using condom shows disregard about your partner (being not faithful)	50.7	26.5	22.8	100.0
"Fung Muk" or injecting oil or substance to enlarge penis satisfy women	21.1	34.9	44.0	100.0

4.9 ATTITUDES TO PEOPLE LIVING WITH HIV/AIDS (PWHAs)

Attitudes towards PWHAs are a critical issue in many countries as families, friends and communities struggle to come to terms with this "unexpected event" in their lives. In many places, the PWHAs and their families are still very isolated, discriminated and abused. The answers from the respondents on these issues are very much predictable (Table 4.37). Most of the respondents categorise HIV/AIDS as a serious communicable disease which can be transmitted by casual contacts such as touching, shaking hands, sharing toilets and bathrooms, sharing the office or house, sharing bed or clothes etc. (see misperception of transmission). In reply to the proposition "if you have an HIV/AIDS positive person in the family, will you let him/her live in the same house with you", 86.0% of the respondents have disagreed to do so and only 11.7% agreed. In another question, 57.3% of the respondents have disagreed to be willing to live and work with HIV positive people. Similarly, 74.1% of the respondents have disagreed that HIV/AIDS positive people should not be isolated and stay with "normal people. Just under half or 45.2% of the respondents refuse to visit an HIV-positive friend.

The means of the scores from all answers are analysed for a correlation by the demographic and migratory experience variables with one-way ANOVA. It shows that there is no significant difference among various age and educational groups. Women have more negative attitudes towards PWHAs than men. Divorcees have a better attitude than single and married people. Among religious groups, Buddhists and Muslims have more negative attitudes than Christians. People who speak good Thai have a significantly better attitude than those who do not speak Thai. There is, however, a significant correlation with the duration of stay in Thailand i.e. people staying over five years have a better attitude than those living in Thailand for less than a year. Like other analyses on various occupational groups, sex workers have a significantly better attitude than the construction workers and unemployed people. People who have a higher income (>4000 baht) have a much more positive attitude than those with no or low income (<500 baht). These findings are consistent with the overall knowledge and with the prevention of HIV/AIDS as described earlier.

Table 4.37: Attitude Towards PWHAs

Situations and Statements	Agree	Disagree	Don't know	Total
Should not hate or be afraid of AIDS patients as it is not easily transmitted	44.0	45.0	11.0	100.0
Should have compassion and sympathy for HIV/AIDS positive people	45.0	50.7	4.4	100.0
Could live and work closely with HIV/AIDS positive people	34.6	57.3	8.0	100.0
If you have a HIV positive friend, you will go to visit him/her	47.7	45.2	7.1	100.0
HIV/AIDS positive people should not be isolated and stay with normal people	18.6	74.1	7.1	100.0
If you have a HIV/AIDS positive person in your family, you will let him/her live in the same house with you	11.7	86.0	2.3	100.0

4.10 RISK SITUATIONS AND RISK BEHAVIOURS

In this section we look into the specific risk behaviours of the respondents as well as surrounding risk situations that influence their vulnerability to HIV/AIDS. This includes their sex behaviours and sexual networking in the community including access to commercial sex. It also discusses IDUs which is directly linked with HIV transmission. While alcohol and non-injectable drugs may not pose a direct threat for HIV transmission, they however have serious implications on people's social and sexual behaviours and therefore are included in this section. Some of the masculine behaviours such as *fung muk* which might have important bearing on HIV/STD transmission are also covered.

The risk situation analysis has been done by interviewing the respondents about their habits of alcohol consumption, drug use, needle sharing, history of blood transfusions, sex behaviours in regular, casual and commercial sex, and condom use in each of these circumstances. Additional qualitative analysis was done by key informant interviews, field observations and a contextual analysis of the situation.

Regular and Casual Partner Sex

Heterosexual intercourse in the main mode of HIV transmission in the region. In most places the 'first wave' of infection spread through commercial sex. Sex workers get infected from their clients and in turn other male clients get infected who then transmit it to their wives, girlfriends and other partners. It is important to identify this locus of infection at the early stage of the epidemic if possible. But as the number of HIV positive people increases in the community, it is much more important to determine the sexual networking outside commercial sex. Because in such circumstances casual and multiple partner sex could become the important source of HIV transmission. So in determining HIV vulnerability of a particular population, it essential that we look into the total sexual networking i.e. regular partner, casual partner and commercial sex.

Table 3.38 shows various forms of sexual encounters of the respondents in the last year. Married people have high rate of regular partner sex. Regular partner here implies to married couples, common law spouse and minor wives i.e. the couple who have continuing commitment towards each othei and have social acceptance as sex partners. Many single and divorcees/widows also claim to have regular sex partners (Table 4.38). Casual partner sex means people who have occasional or incidental sex.

Table 4.38: Sexual Networking by Marital Status

	Single No(%)	Married No(%)	Divorced/Widow No(%)	Total No(%)
Regular couple sex	43(25.6)	196(83.4)	7(24.1)	246(56.9)
Casual partner sex	48(28.6)	37(15.7)	22(79.5)	107(24.8)
Boyfriend-girlfriend	19(11.1)	10(4.2)	9(31.0)	38(8.7)
Commercial sex clients	17(9.9)	8(3.4)	4(13.8)	29(6.6)
No sex	77(45.8)	2(0.9)	0(0.0)	79(18.3)

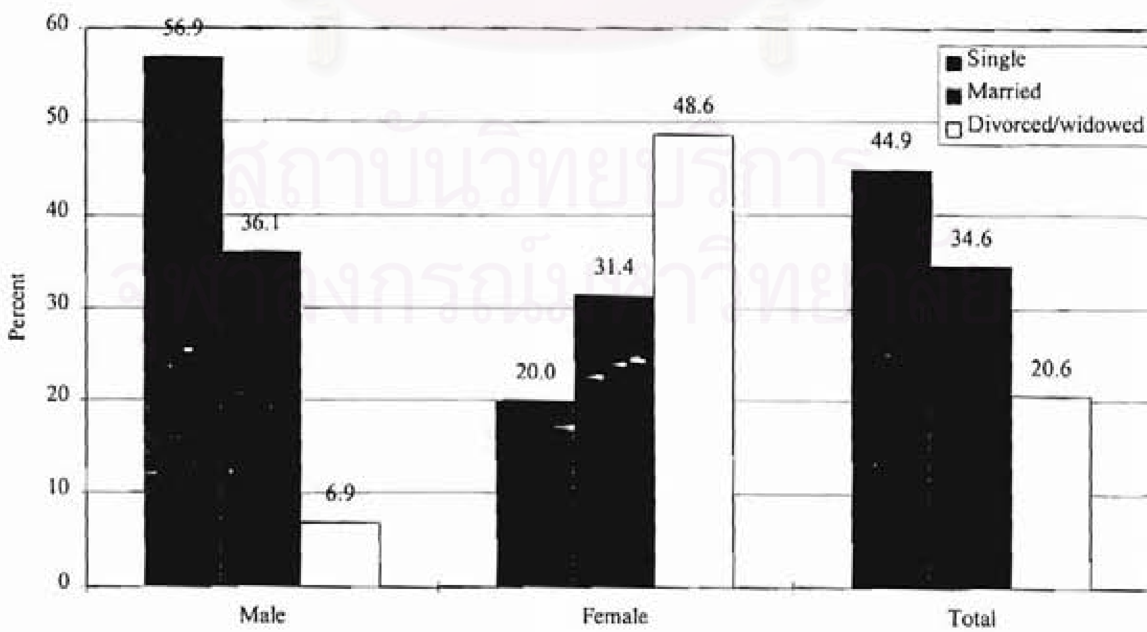
FIG. 4.16: FACTORS AFFECTING HIV RISK BEHAVIOURS OF MIGRANT POPULATION IN RANONG

Shakti R. Paul, ARCM, Chulalongkorn Univer

encounter without any long-term commitment. Interestingly it is common among divorcees and widows but also prevalent among single people and to a lesser degree among married respondents (also see Figure 4.17). Commercial sex is occurs in exchange of money or certain favours and therefore are considered separately. Boyfriend-girlfriend sex relations are somewhat in between the regular and casual, and prevalent among widows and divorcees and single people. Seventy nine respondents or 18.3% did not have sexual encounters in the last twelve months and a great majority of them are single i.e. 45.8% in that category. There is not one widow or divorcee who did not have sex in the last year. This raises the issue of their HIV vulnerability as a great many of them have casual sex. This particular group also has multiple sex partners and some of them work as sex workers. This is important finding for the HIV/AIDS programme as they often ignore this particular population group in their target. Multiple partner sex is also occur among single and to a lesser degree among married people. Overall sexual networking among Ranong migrants is very complex and illustrated in the Figure 4.16.

Casual partner sex: As many as 107 (72 men and 35 women) or 25% of the respondents admitted to having casual sex outside of wedlock or regular partner in the last twelve months. Almost half, 44.9% of them are single, 34.6% are married and 20.6% are divorcees and widows (Figure 4.17). Gender analysis of this particular group reveals some very interesting findings. Among men, 56.9% are single, 36.1% married and 6.9% divorcees but among women 20.0% are single, 31.4% married and 48.6 divorcees. That means that many of the single men are developing a sexual networking with married and divorced women. In another words, 76% of all the divorcees/widows (81% women and 66% men) and 29% of the single people (33% men and 17% women) had casual sex relations (see Table 4.38); and among married respondents, 15.7% (20% men and 11% women). In-depth interviews reveal that many wives of the fishermen feel lonely when their husbands go for a four to six weeks voyage. Sometimes, they also run out of money and need to borrow money or seek help from

Figure 4.17: Casual Partner Sex by Gender and Marital Status



others. Widows and divorcees are in very difficult situations. In addition to their sexual desire they also endure hard times to earn sufficient income to support themselves and their family, which often includes young children. For this reason they often develop relations with men who can provide her much need social and financial support. It is also a fact that many migrant families live in close proximity to each other thus it is not difficult for them to develop sexual relations outside their regular partnership (Paul S. et al, 1997). On the other hand, many fishermen visit sex workers after returning from their hard voyage, sometimes with the encouragement of their peers and boat owners. Some fishermen also have their 'girl friend' among the service girls. This is usually common knowledge among their wives and it is not uncommon to see them quarrel about these issues (Naing, 1999).

Casual partner sex is common among young people in the age group of 21-30 years, especially for those who have been living in Ranong for over five years. There is no significant difference among religious or ethnic groups. Those who have primary or secondary level education are more involved in these activities than those without formal education and more than nine years of education. Among the occupational groups, fishermen are frequently involved in these activities and of course, the sex workers do it regularly in their job.

Commercial Sex

For years Ranong has been known for its notorious brothels and commercial sex industry. It became well-known in 1993-94 when several brothels were identified as harbouring a large number of under-age girls, many of whom were trafficked from neighbouring Myanmar. Social workers and human rights organisations were outraged with the tragic situations of some of the girls rescued from the brothels. Police crackdowns followed and much of the infamous red-light district was closed. Many of the former sex workers dispersed all over the town, however, some were placed in jail in Khawthaung for three years and many were HIV positive (Beesey 1998). Some of the lucky ones returned home in Myanmar. Some others could not return home and failed to find an alternative means of living in Ranong. So they returned to the same job through alternative venues and private networking. What has happened is that much of the direct sex venues (that provide sex services in their premises) are closed now and many more indirect sex services (that do not provide sex services in their premises but provide services in the hotels, guest houses or private homes) have opened. This transformation has led to several changes in the commercial sex industry:

1. Numbers of young or under-age girls or child prostitute dropped;
2. Trafficking and exploitation of girls and women for prostitution reduced;
3. Direct sex service venues (e.g. brothels) drastically reduced;
4. Number of indirect sex services significantly increased with the following characteristics-
    - sex workers are available in the restaurants, bars, cafes, traditional massage parlour, karaoke and at the street corners
    - usually no service in the premises but sex workers accompany clients to their hotel, guest house or private homes;
    - usually older girls and women work in this business but no child prostitution;
    - girls and women have freedom to chose their work and clients
    - relatively easier access and exit in the profession

- serves fewer clients a day usually only one or no client in some days
- relatively better earning and more independent to use her money
- may keep an alternative job such as waitress, masseurs, hairdresser, singer etc
- difficult for the AIDS and social workers to reach them for HIV/AIDS education

Local sources in Ranong estimate that there are about 500 sex workers in the town. Most of them (estimated over 80%) are migrants from Myanmar and the rest are Thai. They operate out of restaurants, beer bars, cafes, karaoke, beauty salon, guest houses and sometimes shadowy street corner. Most of them are concentrated in one particular location near the fishing piers in Pak Nam area of the town. There are an estimated 350 women working as waitresses in 44 restaurants (WVT, 1998). Fourteen of the restaurants are known to provide direct services in their venue. The others range from indirect services that are freely available to any clients. In some establishments the women will only have sex with their 'boyfriends', meaning a regular customer with who they develop 'special' relations with; some boyfriends last for sometime and occasionally resulting in permanent relationships. In the latter cases, some women often have more than one boyfriend and sometimes these boyfriends may fight among themselves to keep control of their relationship. Fishermen are the main clients in this area but there are many other Burmese migrants and some Thai clients too. Considering the large contingent of 27,000 fishermen and half of them being single, there is a lot of demand for commercial sex. Ranong port also harbours many other fishing vessels and ships from outside. The area has rapidly developed since 1996 and on both sides of one street are numerous restaurants with lights and music and video screens, and many young women beckoning customers from the street.

Thirty migrant sex workers were interviewed in the questionnaire survey and some of their characteristics are given in Table 4.38. Most of them are 21-30 years old with only a few younger and older ones. With the exception of one male, 29 of them are female. Interestingly, 14 out of 30 of the sex workers originated from Yangon, nine from Tanintharyi and others from various places which indicate that the distance is not a limitation. Eleven of them are married, 14 divorced or widowed and only five of them are single. Many of the divorcees came to Ranong with their husbands and were later separated or abandoned by them. Some of the married women working here have a similar situation as the divorcees. Twenty of them are Burmese and only one of them Mon. Half of the girls had more than six years of education and only five had no formal education. So lower education was not the main factor for entry into this occupation but other socio-economic circumstances have determined their decisions. Almost all of them did not have any decent job in Myanmar, and in fact, many of them were unemployed, either as a student or a small trader. All of them say that nobody forced or persuaded them to come to Ranong. Seven of them openly say that they decided to do this kind of work. Eleven of them have been working in Thailand for over three years including nine more than five years. They claim to have a good income and 23 of them earn over 4,000 baht per month. This is a good income for migrant workers and in fact they are the highest earning group among all of the occupations. If they work in other occupations they have to struggle with the employers, local police and long hours of work and much less pay.

Table 4.39: Characteristics of Sex Workers in Ranong

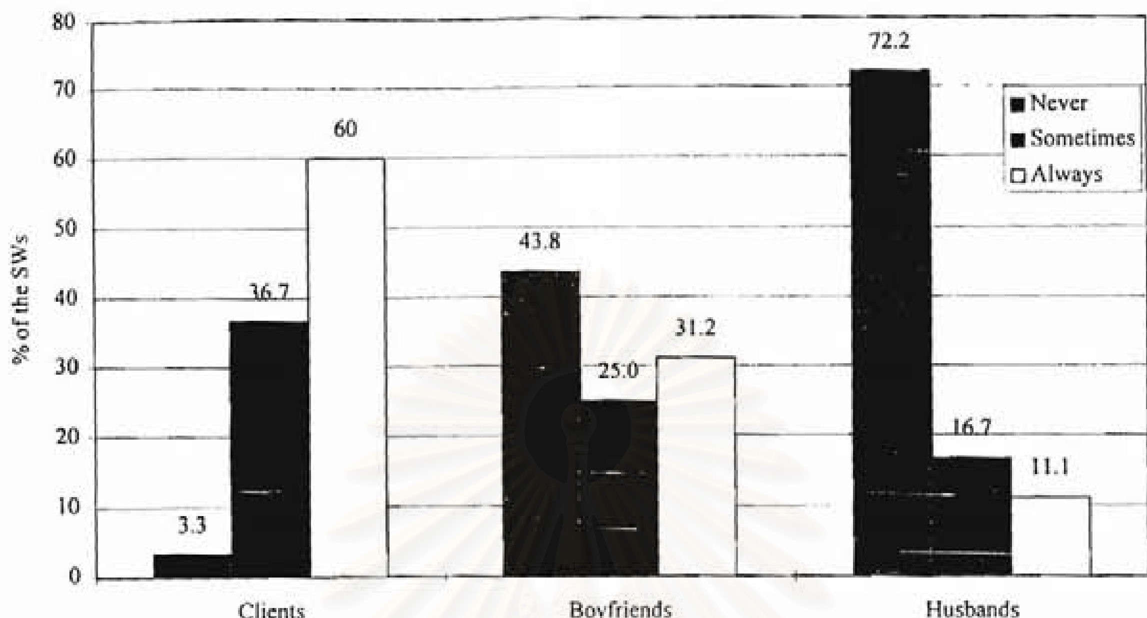
Age groups	20 years or less	21-30 years	31-40 years	Over 40 years
Numbers	5	20	3	2
Education level	No education	1-5 years	6-9 year	Over 9 years
Numbers	5	10	14	1
Ethnicity	Burmese	Tavoy	Karen	Others
Number	20	3	3	4
Marital status	Single	Married	Divorce/widowed	
Number	5	11	14	
Length of stay	0-11months	12-35 months	36-59 months	Over 59 moths
Numbers	8	11	2	9
Speak Thai	None	Little	Moderate	Good
Numbers	10	18	1	1
Income range	1-500 baht	1501-2000 baht	2001-4000 baht	Over 4000 baht
Numbers	1	3	2	23

One interesting finding of the study is that sex workers have the highest level of knowledge about HIV/AIDS than all other occupational groups in Ranong. This is the result of many years of hard work of the WVT project staff with this group. Like many other similar situations, this increased knowledge do not appear to change their risk behaviours i.e. increased use of condoms or reducing drug use.

About 60% of sex workers claim to have always used condoms with their clients, 37% sometimes and 3% never (Table 4.15). But data is different from the clients of the sex workers, 28% of whom claim to have never used condom with the sex workers. Regular use of condoms by the sex workers also drops to only 30% with their boyfriends and 10% with their husbands. The reasons for not using condoms are too familiar. Men often raise the question of their faithfulness, decreased pleasure and general disliking to use condom. Low use of condoms with boyfriends and husbands are very critical as many sex workers have more than one boyfriend and some of them change their boyfriends quite often. For example, when a fishermen boyfriend is on a trip she finds another man for both income and pleasure. Similarly, boyfriends and husbands also have multiple partners and they visit sex workers elsewhere. So in this vulnerable situations 'unsafe sex' is particularly dangerous but it seems that their existing knowledge have not made much impact on their behaviour.

Availability and cost of condoms has been of particular concern to some sex workers. They claim that many clients often do not bring condoms with them and the girls have to carry condoms with them if they really want to use them. So they have to buy them in the market which can be embarrassing but more importantly, they want to bear the cost. This is one of the reasons why they do not use it with their husbands or boyfriends.

Figure 4.17: Condom Use by the Sex Workers in Various Circumstances



As stated earlier, because of their indirect nature of sex work it is difficult to organise regular check ups for STDs and HIV/AIDS. If they have STD and genital problems they usually treat them by purchasing drugs. Some of them go to Kawthaung hospital or private clinics. They often come to WVT clinic at a late stage when they fail to cure it with other methods. In this situations they become much more vulnerable to HIV than other normal individuals.

Finally, HIV prevalence among migrant sex workers was also very high between 1992-94 when testing was done regularly along with the Thai sex workers. HIV-positive rates among migrants ranged from 50-65% at that time compared to 30-50% among the Thai sex workers. Since 1995 after closing brothels and difficulty in organising sentinel surveillance HIV testing was done on an ad hoc basis. A survey in 1998 among a large number of indirect Myanmar sex workers the HIV-positive rate was found to be 33.77%. So HIV/AIDS remains a serious problem among migrant sex workers in Ranong and they continue to play a very important role in the overall HIV/AIDS risk situation.

Condom Availability and Use

Of these 107 people, 38 (35.5%) have used condoms every time, 37 (34.6%) only sometimes, and 32 (29.9%) never (Table 4.40). Condom use is high in commercial sex compared to other partners especially casual sex encounters with neighbours or friends. Condom use is not common in the boyfriend-girlfriend situations of which 62.8% are never using condoms and 20% are using them only sometimes. It is almost never used in regular partner sex.

Availability and cost of condoms has been of particular concern to many migrant in Ranong. They claim that condoms are very expensive for many especially if they want to use it in regular partner sex. A three piece packet costs about 40 baht in the local market and good quality brands are more expensive. This is one of the reasons why they do not use it with

their husbands or boyfriends. "If condoms are cheap and easily available, then many more people will use" says a HIV/AIDS worker in Ranong. He continues, "now that they have the knowledge, they want to use it; but they just can not afford it at such a high cost".

Table 4.40: Condom Use by Various Circumstances

Circumstances	Never		Sometimes		Always	
	Number	%	Number	%	Number	%
Within regular couple*	201/217	92.6	12/217	5.5	4/217	1.8
Casual partner sex**	32/107	35.5	37/107	34.6	38/107	29.9
Boyfriend-girlfriend**	22/35	62.8	7/35	20.0	6/35	17.1
Clients with sex workers	9/32	28.1	5/32	15.6	18/32	56.3
Sex workers with clients	1/30	3.33	11/30	36.7	18/30	60.0
Sex workers with boyfriends	7/17	41.2	5/17	29.4	5/17	29.4
Sex workers with husband	14/19	73.7	3/19	15.8	2/19	10.2

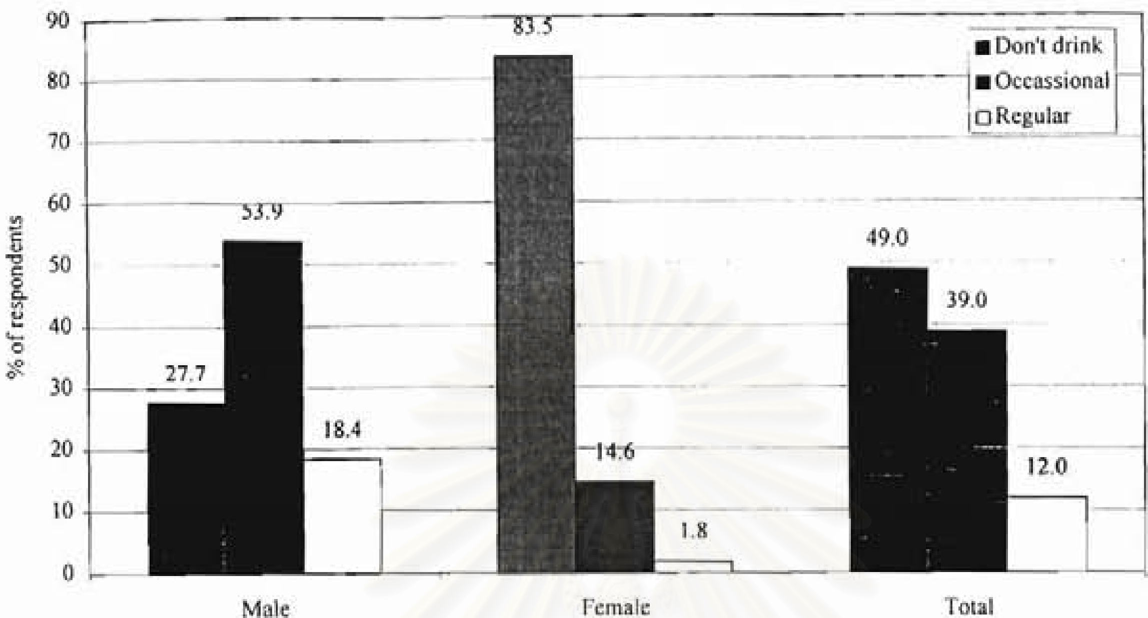
** married couples or steady partners; ** temporary, not considered as regular couple*

Sexually Transmitted Diseases (STDs) are quite common among certain population groups. Thirty respondents (14 men and 16 women) or 6.9% have reported to have suffered from some form of STD in the last year. Among men, nine are fishermen, two factory workers, two service workers and one construction worker. Of the women, 13 are sex workers, two service girls and one unemployed. It has not been possible to establish an exact diagnosis of their illnesses but most of them had purulent discharge with or without itching. Some of them also had genital ulcers. As indicated elsewhere, STDs are thought to be common in this population, although WVT report shows decline over last few years. A more detailed studies will certainly help to better understand the situation. As for the treatment of these 30 suspected cases of STDs, one went to Thai hospital, four to WVT clinics, five to a private Thai clinic. Nine respondents had not sought special care but treated themselves in Thailand and four used some other methods. A few went to a Myanmar hospital and private clinics.

Drugs, Substance and Alcohol Use

Alcohol consumption is very common in this fishing community. Of the total 436 respondents, 12.0% drink alcohol regularly, 39.0% sometimes and 49.0% never (Figure 4.18). As expected there is a significant gender difference for alcohol consumption. Looking at the numbers for men and women, 18.4% of the men drink regularly and 53.9% occasionally, compared to 1.8% of women who drink regularly and 14.6% occasionally. There is no significant difference between various age groups as many of them including young people drink freely. Drinking is a very popular way of recreation for fishermen and often together with the service girls and sex workers. They think that by getting drunk they will overcome the hard work in the sea, harsh treatment from their Thai boat owners and also boredom and loneliness they endure in their mobile life from port to the sea.

Figure 4.18: Alcohol Consumption by Gender



Those who stayed longer than five years in Ranong are likely to drink more than the other respondents. Interestingly, people with higher education and income drink more than those with lower education and income. Surprisingly, Karen in Ranong are reported to drink more than the Mon, which is the opposite case in Sangkhlaburi. This might be because most of the Karen in Ranong are Buddhists unlike in Sangkhlaburi where many are Christians. Alcohol has strong influence on people's social and sexual behaviours. Those who drink more are likely to visit sex workers or have casual sex partners. Alcohol also influences condom use, "drunkards do not like to use condom", says a sex workers and "some of them are so drunk that they can not put on it" she adds.

Injecting Drug Use (IDU): Nine respondents - five men and four women - have reported injecting drug use and six of them shared needles with others. They belong to a wide range of occupations - one agriculture worker, three fishermen, one fish related worker, one service staff and three sex workers. IDUs are a serious problem among certain population groups in Myanmar and Thailand, two countries that are part of the so-called "golden triangle" drug producing area. The areas adjacent to Ranong are not so well known for drug trafficking and IV drug use, but the area was never been seriously investigated. Once again, the Burmese fishermen claim that many Thai boat captains and supervisors take drugs. Apparently drugs are supplied by the supply boats in various ports. They are not, however, so sure if these drugs are meant for consumption or trafficking to other places. Altogether 36 respondents claim to have taken some injection for treatment of their ailments. Injectable medicines are very popular among all types of Burmese and sometimes it is provided by untrained personnel. Some respondents admit that in most instances they reuse the needles without proper sterilisation.

Marijuana has been used by 25 respondents (5.8%) in last one year, all of them being men. With the exception of one, all of them claim to have taken it occasionally. Nine respondents have reported to have stopped taking it altogether. Ten respondents reported the usage of

methamphetamines, another common drug used in Thailand and many of its neighbouring countries. Amphetamines are one of the rapidly growing drug addictions that affect youngsters and many other population groups. Many of the drug production rackets have moved into Myanmar and other countries because Thai government has been implementing stronger drug control measures. This has resulted in a wider use of the drug in those newer places in Myanmar. Burmese fishermen claim that they cannot afford to buy amphetamine pills at a cost of 250 baht a piece. They often take some kind of cough tablet (blue pills) or Phensidyle syrup. But they believe that many of the Thai fishermen who are captains and supervising engineers take amphetamines.

Blood transfusion: Kawthaung and many other border areas inside Myanmar are known for their notorious drug resistant falciparum malaria. Many of these malaria victims become anaemic and often require blood transfusions. Other patients also receive transfusions such as delivery complications, major surgery and accidents. Sixteen respondents received blood transfusions in the last year - seven in a Thai hospital, eight in Burmese hospital and one in a Burmese clinic. HIV screening of blood is available in both hospitals in Ranong and Kawthaung, so the transfusions are assumed to be safe.

***Fung Muk*:** One of the interesting traditions of some fishermen and other Burmese men is to insert pieces of marble stone or other kind of hard object under the skin of their penis, *fung muk*. They believe that this increases their sexual gratification for themselves and their partners too. Twenty (7.4%) male respondents claimed to have *fung muk* inserted at the time of the interview. Eighteen of them are fishermen, one each fishery related and service worker. The procedure of *fung muk* or subsequent effect may lead to infection and ulceration of the penis or may cause injury to the genitalia of the their partners, which increases their vulnerability to STDs and HIV infection.

Oil injection in the penis: At least 14 of the male respondents (or 5.2% of men) admitted to have injected oil into the glans penis to increase its size. Eleven of them are fishermen, two service workers and one works in the fishery related sector. Some people still believe that having an enlarged glans penis will provide extra stimulation to their female partners.

Self-assessment of HIV Vulnerability

Towards the end of an approximately twenty minutes interview, the respondents are asked to make a self-assessment of their own vulnerability to HIV/AIDS by taking into consideration their knowledge, attitudes, beliefs and practices about the disease. They are given an option to choose a single answer from among no risk, low risk, medium risk, high risk or do not know. A great majority of all respondents or 73.2% have answered no risk, 10.3% do not know and only a few said low or high risk. It is quite possible that these answers are at least in part influenced by their attitude towards the PWHAs, which means that many people can not simply think of themselves as being one of those unfortunate people. However, when the same question is asked to the people who had extra-marital or pre-marital sex (n=107), and those who did not have casual sex (n=329), the answers differed (see Table 4.41). The former group agrees to be at more risk than the latter group. Interestingly, there is no significant difference among various age, gender, marital status, religion, ethnicity, length of stay, education, Thai language ability, occupation or income groups. This means that this "misperception of HIV vulnerability" cuts through all walks of life of people. Among those

who had pre- and extramarital sex but have used or not used condom, the assessment of their HIV vulnerability does not differ. It proves that many people are still not so sure how to assess their own vulnerability which might be one of the key factors to encourage them to take up preventive measures seriously.

Table 4.41: Self-assessment of HIV Vulnerability by Sexual Behaviour

Sexual Behaviour	No risk	Low risk	Medium risk	High risk	Not sure
Regular partner sex	79.7	6.8	3.4	0.6	9.5
Casual partner sex	54.2	13.1	12.1	8.4	12.1
always use condom	71.1	10.5	--	5.3	13.2
sometimes use condom	21.6	16.2	32.4	13.5	16.2
never use condom	71.9	12.5	3.1	6.3	6.3
Commercial sex clients	59.4	15.6	12.5	--	12.5
always use condom	66.7	11.1	22.2	--	--
sometimes use condom	20.0	--	40.0	--	40.0
never use condom	66.7	22.2	--	--	11.1
Total 436 respondents	73.2	8.3	5.5	2.8	10.3

When asked what would be the primary reason for them to think seriously about HIV prevention. Over one-third (35.6%) say they are afraid to die; the response is similar in men and women (Table 4.42). The second largest group (24.0%) say they don't want to transmit to their families and another 20.3% say they are ashamed of it. A significant group of 16.2% respondents say that they are persuaded by NGOs to prevent HIV; but not so sure why they have to do it. There are more men than women in this group because many fishermen still have a 'don't care' attitude towards prevention which is evidenced by the fact that despite having high level of knowledge they still engage in high risk behaviours. Married people are more afraid to die than the single people and once again, most of them are fishermen. People with higher education are more ashamed of it than those with lower education. There is no significant difference among ethnic or religious groups.

Table 4.42 Reason for Thinking About HIV/AIDS Prevention

Reasons	Male (%)	Female (%)	Total (%)
Don't think	1 (0.4)	2 (1.2)	3 (0.7)
Persuaded by NGOs	55 (20.4)	15 (9.2)	70 (16.2)
Afraid of death	95 (35.2)	59 (36.2)	154 (35.6)
Ashamed of it	56 (20.7)	32 (19.6)	88 (20.3)
Transmit to family	55 (20.4)	49 (30.1)	104 (24.0)
Others	8 (3.0)	6 (3.7)	14 (3.2)

Multivariate Analysis

Multiple regression was undertaken for further clarification of the study finidngs. The variables tested pertaining to HIV/AIDS knowledge are analysed by linear regression and those pertaining to HIV risk behaviour by logistic regression.

1. HIV/AIDS Knowledge

Knowledge as the dependent variable, includes general knowledge of HIV/AIDS as well as on transmission, symptoms, testing, prevention and cure as discussed in the section 3.7, all of which are combined to form overall knowledge for this analysis. The predictors are selected from 20 demographic and migration variables which are all tested against knowledge as the dependent variable. Demographic variables are: age, gender, education, ethnicity, religion, marital status and occupation. Migration variables are: hometown or place of origin, previous occupation, encouragement for migration, prior information about Thailand before migration, contacts with hometown, income, savings, sending remittances, length of stay, place of living, living with whom,, community participation, rest and recreation activities and Thai language proficiency. Aother variable used is self-assessment for risk of contracting HIV.

Table 4. 43: Multiple Regression of Demographic and Migration Factors on HIV/AIDS Knowledge

Predictor	β	t	sig
1. Higher education	.294	4.895	.00
2. Place of origin			
-Bago	.389	2.064	.04
-Irrawaddy	.496	2.428	.02
-Magwe	.291	2.028	.04
-Mandalay	.355	2.209	.03
-Tanintharyi	1.082	2.244	.03
-Yangon	.743	2.140	.03
-Mon	1.052	2.208	.03
3. Listening Thai	-.271	-2.819	.01
4. Occupation - construction	-.259	2.176	.01
5. Gender-male	.181	.2.076	.04
6. Accommodation circumstances -			
-Stay with same sex	.183	2.331	.02
-Compound family	.126	2.054	.04
7. Self assessment	.147	2.531	.01

R = .409 F = 3,504 Sig = .00

Table 4.43 describes the predictive variables that have positive or negative correlation with dependent variables. They are seven variables of which five have positive and two negative correlation with knowledge. Higher education has positive correlation with knowledge and men are more likely than women to have good knowledge. Those who originated from Bago, Irrawaddy, Magwe, Mandalay, Tanintharyi, Yangon and Mon State have better knowledge. Those who stay with the same sex friends and compound family also have better knowledge. Respondents who work in the construction sector have poor knowlege.

2. Risk Behaviour

Risk behaviours, defined here as casual partner sex and visiting CSW is the dependent variable. The predictors are selected from the demographic and migration variables, as described above, plus attitudes on two areas, namely: attitudes towards PWHAs and attitudes towards social (sexual) norms as well as overall knowledge score and self assessment of risk. Logistic regression is used for the analysis.

2.1 Casual Partner Sex

In Table 4.44, there are five significant variables that have positive correlation to have casual partner sex. They are worked somewhere before, self assessment of high risk, divorced marital status, recreation by drinking and visiting entertainment places and gender male.

Table 4. 44 Multiple Regression Analysis of Risk Behaviour: Casual Partner Sex

Predictors	B	S.E.	R	sig
1. Worked somewhere before	1.6168	.5796	.1162	.01
2. Self assessment	.4821	.2495	.0637	.05
3. Marital status: divorced	3.6251	.1363	.1382	.00
4. Recreation: drink & entertain	1.4744	.3527	.1002	.00
5. Gender - male	2.5397	.8394	.1293	.00

2.2 Visit Sex workers

In Table 4.45, there are four variables that have significant positive correlation to visit sex workers. They are occupations as fishermen and labourer, recreation by drinking and visiting entertainment places, accommodation with same sex friends and ethnic Karen.

Table 4. 45: Multiple Regression Analysis of Risk Behaviour: Visit Sex Workers

Predictor	B	S.E	R	Sig
1. Occupations - fishermen	3.1027	.7490	.2674	.00
- labour	2.8475	.9995	.1698	.00
2. Recreation - drink & entertain	2.1623	.5381	.2583	.00
3. Accommodation's condition				
- stay with same sex	1.3567	.5339	.1450	.01
4. Ethnic – Karen	2.2107	.9838	.1199	.02

Summary and Discussion of HIV/AIDS Risk Situation

In summary, the migrant population in Ranong has a relatively good knowledge of HIV transmission, symptoms and cure especially when compared with the migrants in Sangkhlaburi. They still have some misperceptions of the disease and in some instances they are simply not sure what it is all about. Most of the people have heard about HIV/AIDS and STDs by talking to someone else and only a smaller proportion learned through recognised methods such as television, newspaper and posters. It is evident from this study that at least some of the messages they receive by talking to other people are often not correct or lack detail.

High risk behaviours for HIV transmission among this population do exist in many respects. Like any other society, the people continue to have unprotected sex outside their usual partnership. This is especially common among people living in groups and without a nuclear family. Divorcees and widows are particularly vulnerable to unprotected sex and they are also likely to have multiple partners. A significant number of them are also involved in commercial sex. The commercial sex industry is very active in Ranong and regularly patronised by certain groups of people. Fishermen in particular have close relationships with sex workers. They often visit them while onshore, not only in Ranong but also in other ports they visit in Thailand and Myanmar. The actual number of sex workers in Ranong is also an important issue to consider for the HIV/AIDS situation. Following closure of the brothels, the sex industry in Ranong is wide open and many service and entertainment establishments now have indirect sex workers at places such as restaurants, coffee shops, karaoke, traditional massage, discotheques and snooker clubs. Some men and women working in these establishments will be willing to provide sexual services at the hotels and guest houses.

There are also men and women travelling to other parts of Thailand and at least some of them are exposed to unprotected sex at their destinations. They mix among the people in Ranong and adjacent areas. From the limited available data, it can be seen that STDs do exist in the migrant population in Ranong. According to NGO clinic data, STD prevalence has dropped over the past years (WVI 1998) but interviews with the women reveal that a significant number of them still suffer from various forms of reproductive tract infections (RTIs) (Paul, S. et al. 1997).

Drug and substance abuse appear to exist among certain population groups. Three out of 128 fishermen and three out of 30 sex workers admit to take IV drugs. More detailed assessment, analysis and intervention is needed concerning this issue. Similarly, some respondents have reported to have consumed marijuana and amphetamines.

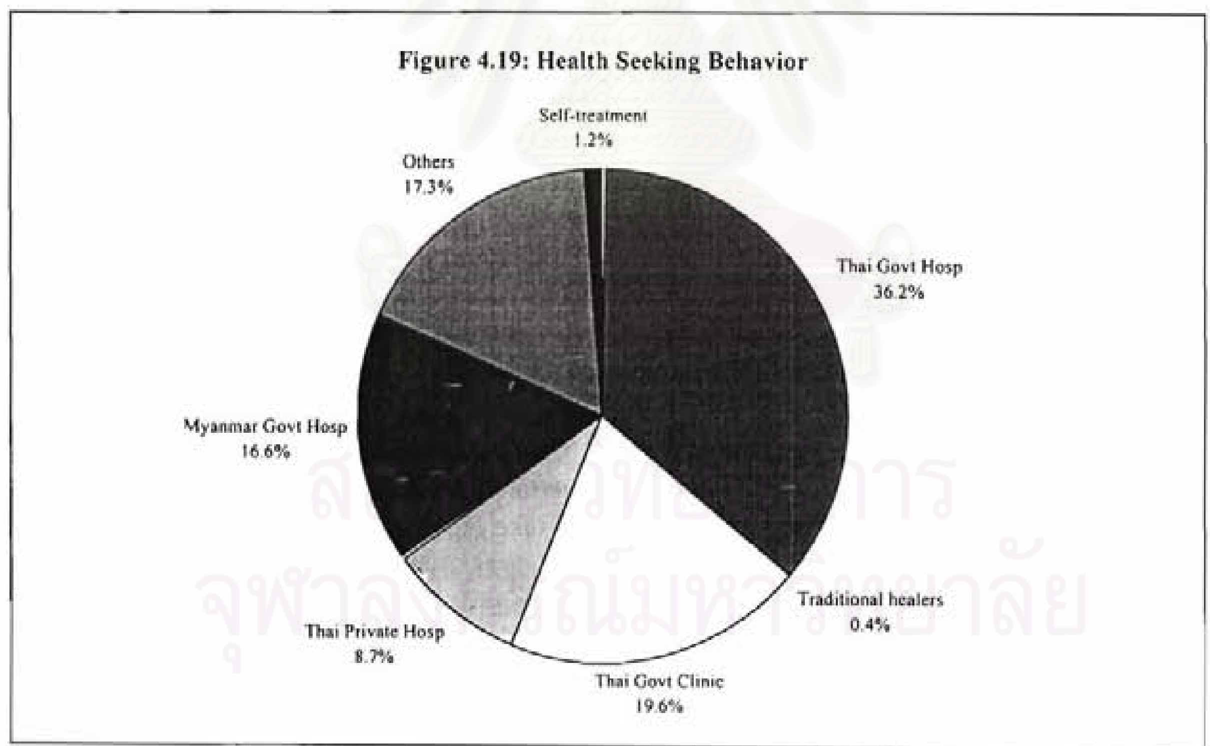
Given all the facts in the above sections, it can be concluded beyond doubt that much of the migrant population in Ranong is very vulnerable to HIV transmission. Despite the presence of a well organised HIV/AIDS project that has significantly improved the knowledge of the migrants, transmission still continues in some 'hard core' population groups such as fishermen and sex workers. Other population groups have relatively lower frequencies of high risk behaviour, but they are handicapped by poor knowledge and preventive practices to protect themselves from the disease.

4.11 HEALTH SEEKING BEHAVIOUR AND HIV/AIDS SERVICES

Provision of health care services are intimately related to HIV/AIDS vulnerability of a population. In addition to the general health care, some specific services are directly related to prevention and care HIV/AIDS: (i) health and HIV/AIDS education and awareness, (ii) supply and distribution of condoms, (iii) education, diagnosis and treatment of STDs, (iv) voluntary counselling and testing (VCT), and (iv) hospital or community based care of PWHAs etc. In most places these services are integrated into the existing health system that people are familiar with. This is also the most cost effect effective way to develop these services but it may also add to the burden of the precarious state of the government resources. A large number of 85.3% respondents know about health services in Thailand but only 47.2% ever visited a hospital. The reasons for the low number of visits are either they have never been sick, the high cost of treatment, the difficulty of communicating with hospital staff in Thai language, or receive poor treatment they receive because of their migrant status.

When asked where they will usually go for treatment if they become ill in the future, 36.2% preferred Thai government hospital, 19.6% Thai clinic, 16.6% Myanmar government hospital and 8.7% a Thai private clinic (Figure 4.19). The rest will go to various other health services including private clinics, drug stores and traditional healers.

Figure 4.19: Health Seeking Behavior



There is no significant difference among various age groups, gender, education and length of stay with the health seeking behaviours. Among occupational groups, construction and transport workers are more likely to go to the Thai hospital. The sex workers and fishermen prefer a World Vision clinic. Those who speak better Thai are more likely to go to the Thai hospital than those who do not speak Thai. One surprising finding of the study is that the respondents show little preference for traditional healing practices which was thought to be

common among many rural folks and ethnic minority groups in Myanmar, and elsewhere in the region.

HIV/AIDS/STD Patients

Patient statistics provided by the hospitals and clinics show a significant number of HIV positive people in the area (see section 4.3). Ranong hospital has already recorded 304 AIDS patients and another 96 symptomatic HIV in last six years (1992-98). The number of HIV/AIDS cases increased significantly in last two years i.e. 1997-98. HIV/AIDS prevention and care services are discussed in section 4.2. WVT in collaboration with the public health department runs a clinic near the port area. They provide a range of OPD care to all people who attend the clinic. They also provide treatment for STDs, and voluntary counselling and testing for HIV. In addition, they organise community based primary health care programme including HIV/AIDS education in six communities (pop. 15,000). WVT project also provide care and support to the identified PWHAs in the area either in the clinic or its community based care activities. Number of patients seeking care in the clinic are gradually increasing and they have already recorded death of several known patients. In addition to providing care in Ranong, WVT has also developed a referral system to transfer patients from Ranong to Kawthaung through its sister agency WVM there. This referral system helps to send PWHAs to their families and care at home.

After about five years in operation, WVT is struggling with some of the major issues e.g. dependence of the project for outside funding, lack of employers involvement in the care of their staff, and expansion of similar activities to the remaining 62,500 migrants. Ranong public health department is aware of these situations but is yet to come up with any lasting solution to these issues. They are not also not so actively involved in the WVT programme except for joint operation of the clinic. But as a whole, HIV/AIDS programming for migrants in Ranong has made significant progress and could become a model for similar activities in other similar situations.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

4.12 SUMMARY AND RECOMMENDATIONS

Ranong-Kawthaung is a unique sea-border crossing between Thailand and Myanmar. Kawthaung or Victoria Point is the remote southernmost town of Myanmar in a sparsely populated area. In recent years its population has swelled because of ever increasing migration to and mobility within Thailand. Ranong Province in Thailand is famous for its well developed fishing industry and plantations, which are both labour intensive. Its own population does not satisfy the job demand which resulted in immigration of labourers from other places mostly from neighbouring Myanmar. Of the estimated 100,000 migrants in the province 77,500 are living in the Muang district. Migrant population in the Muang district is almost equal to the number of the local population where the economic and social life of the migrants is mixed with that of the local. Quantitative data was collected by a structured interviews with 436 respondents using representative samples in regards to their occupation. Additional qualitative data were taken from key informants and four focus group discussions.

Key Study Findings

Migration Situation

1. Of the estimated 100,000 migrants people in Ranong province, 77,500 stay in the Muang district. Over 55% of the migrants stay in families and the family members constitute about 20% of the total population. Ethnically, most of them are Burmese and relatively smaller numbers are Mon, Tavoy and Karen, most of whom originated from Tanintharyi and Yangon divisions of Burma and Mon state (sections 4.5 and 4.6).

2. About half (48.8%) of the respondents have lived in Ranong for over three years including 27.4% more than five years (section 4.6). There are still a lot of people who are there only for a short time, or in transit, especially those who (plan to) travel to central and southern Thailand, Malaysia or Singapore. Almost all migrants intend to return home after they have saved some money to begin a new life in Myanmar.

3. About 38% of the respondents in Ranong are women (section 4.5). Women are employed in a wide variety of jobs such as fisheries related, agriculture, service and domestic work, construction, water transport and commercial sex. In addition there are many housewives who accompany their husbands and families.

4. Illegal status of migrants is a major source of concern (section 4.6). Because of this they become a constant target of police crackdowns, arbitrary treatment by the employers, improper workers benefits, and difficulty in accessing health services. It also seriously limits their ability to develop community structures, spirit and 'self-help groups'.

5. Fishing is the dominant industry in Ranong that employs about 35% of the migrants (section 4.5). Another 17% work in the fish-related work such as sorting and icing of fish, drying fish etc and 19% work in the service sector including domestic help. Smaller numbers of people work in agriculture, water transportation, manufacturing, construction. Overall migrant communities in Ranong are heavily influenced by the fishermen and the sub-culture that arises from heavy drinking and commercial sex.

HIV Risk Situations

6. Overall women have lower socio-economic status in the migrant community because of their low education and skills, job and income opportunities, and social hierarchy. They also have lower knowledge about HIV/AIDS than men. These combined factors make them increasingly vulnerability to HIV/AIDS transmission.

7. Through a complex network of regular partners, casual and commercial sex among migrants (see section 4.10), a large number of people are vulnerable in the widespread transmission of HIV/STDs in the population. The epidemic here has now grown beyond commercial sex and fishermen, and is prevalent in the general population.

8. Both single and married men have high probability to have casual and commercial sex (section 4.10) especially among those who stay with male friends, drink alcohol and visit entertainment places. Divorced women are more likely to have casual sex and be involved in commercial sex but casual sex also occurs among married and single women.

9. Among various occupational groups, fishermen, fishery related workers and day labourers are more likely to visit sex workers. Ethnic Karen visit sex workers especially those who stay with male friends.

10. Condom use is very low in this highly vulnerable situation (section 4.8). It is still lagging behind in commercial sex (60%), sometimes used in casual sex (30%) and almost non-existent in regular partner sex (2%). Availability and costs of condom are cited among the main reasons for low use.

11. Sex workers and fishermen have high knowledge of HIV/AIDS which is the result of five years of WVT programme in these two population groups. Construction workers have significantly low knowledge. But all migrants have many misperceptions about transmission, prevention and cure of HIV/AIDS which continue to influence their risk behaviours.

12. Higher knowledge of HIV/AIDS in sex workers and fishermen are yet to make significant change in their risk behaviours (section 4.8). They are more likely to have unsafe sex and use drugs than any other occupational groups with lower knowledge. It is therefore imperative that their knowledge needs to transform into some applied life skills.

13. There are a number of Thai population groups who are vulnerable to HIV/AIDS e.g. fishermen, truckers, traders and tourist and visitors. Some local people also patronise sex workers and have sexual relations with the migrants that make them vulnerable to HIV.

14. Lack of alternative recreational opportunities is often cited by the migrants as the main reason for high risk behaviours. But the study found that peer pressure and complex socio-economic interactions are the causes of increased alcohol consumption, commercial and casual sex, and drug use among many.

15.All in all, people with better knowledge of HIV/AIDS have better attitude towards PWHAs which is conducive to the development of positive environment for them. Better knowledge also helps to develop better attitude towards sexual behaviours and acceptable norms e.g. more inclined with casual and commercial sex.

Health and HIV/AIDS services

16.Access to public health care system in Ranong is a problem for many migrants. Illegal status, language barriers and high cost of treatment make it difficult for them get services in Thai hospitals. While emergency medical services are generally available, preventive care including HIV/AIDS services are inadequate. In absence of any special fund for the migrants, usually they share patients' budget for the care of the migrants. There have been some discussion about various pre-paid or user-fees schemes to finance the health care.

17.WVT in collaboration with the public health department runs a clinic near the port area. They provide a range of OPD care to all people who attend the clinic. They also provide treatment for STDs and counselling and testing for HIV. In addition, they organise community based programme including HIV/AIDS education and other activities in six communities (popn. 15,000). After about five years in operation, they are struggling with some major issues e.g. dependence of the project for outside funding, lack of private sector (employers) involvement and expansion of similar activities to the remaining 62,500 migrants.

18.Private sector businesses that employ the migrant workers are not involved in the health care and social security of their employees. Some of them are showing an interest to support these activities, which should be consistently pursued at all level, such as the Thai-Myanmar Fishery Coordination Centre and Saphanplar State Enterprise, boat and pier owners etc.

19.Migrant occupational groups are interrelated for their existence, livelihood and services. Many of them also change jobs intermittently among occupations. Therefore, their health care programmes including HIV/AIDS should be integrated with each other programmes to achieve complementary results. While it might be necessary to discuss each industry in its own merits, it is however very important to maintain proper co-ordination among them.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Finally, the findings of the multivariate analysis of the factors determining HIV/AIDS situations in Sangkhlaburi are presented in Figure 3.20. It shows a number of variables having effects on higher knowledge of HIV/AIDS, and some variables that are related to higher likelihood for casual partner sex.

Figure 4.20: Factors Determining HIV/AIDS Situations : Findings of the Multivariate Analysis

1. Factors determining HIV/AIDS knowledge, prioritised by sequence as follows:

Higher education	- high knowledge
Places of origin: all divisions and Mon state	- high knowledge
Thai language (capacity) :godd	- low knowledge
Occupation: construction	- low knowledge
Gender: male	- high knowledge
Accommodation: same sex friends & c/family	- high knowledge
Self assessment: high risk	- high knowledge

2. Factors determining risk through 'casual partner sex' are as follows:

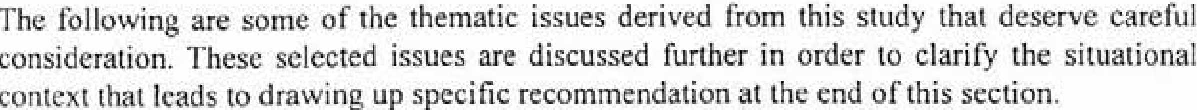
Occupation: sex workers	- high likelihood
Recreation: drink and entertainment	- high likelihood
Gender: male	- high likelihood
Marital status: divorced	- high likelihood
Self assessment: high	- high likelihood
Accommodation: same sex friends	- high likelihood
Community participation: often	- high likelihood
Frequency of visit to Thailand: more	- high likelihood

3. Factors determining risk through commercial sex, prioritised by sequence as follows:

Occupation: fishermen, fish related and labours	- high likelihood
Recreation: drink and visit entertainment places	- high likelihood
Accommodation: same sex friends	- high likelihood
Ethnicity: Karen	- high likelihood

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Discussions



The following are some of the thematic issues derived from this study that deserve careful consideration. These selected issues are discussed further in order to clarify the situational context that leads to drawing up specific recommendation at the end of this section.

1. Migration pattern

The population movement at Ranong-Kawthaung is rather intense despite access difficulties to Kawthaung from inside Myanmar. Usually people have to endure a long treacherous journey through the hills and mountains or underdeveloped waterways to arrive in Kawthaung. While the poor economic conditions and opportunities at home have been cited as the main reason for migration, the real 'push factor' is a complex socio-political-economic situation in the country. Past years of economic prosperity and job opportunities in Thailand have been the main 'pull factor'. Most of the migrants used their personal contacts and information in making the decision to come to Thailand. There is hardly any organised agency to help them with information and travel arrangements inside Myanmar. However, those who wish to travel beyond Ranong must go through one of the several travel and recruiting agents in Ranong or Kawthaung. However, reported cheating and exploitation during travel in Myanmar is said to be minimal as most people travel in groups of friends and relatives. Myanmar migrants in Ranong can be categorised into three main groups based on their intended destinations - (i) those who stay and work in Ranong, (ii) those who travel to central and southern regions in Thailand, and (iii) those who travel to Malaysia and Singapore. However, significant overlapping exists among these three groups depending on their original intentions, financial capacities, contacts at the destination and travel arrangements. Not everybody who wishes to travel to Bangkok or Kuala Lumpur is successful in doing so. On the other hand, some of those who have managed to go destinations outside Ranong might have been deported or repatriated to Ranong by Thai immigration officials.

Ethnically, there are more Burmese and a relatively smaller proportion of Mon, Tavoy and Karen in Ranong. About half of the migrants have lived in Ranong for over three years including a quarter who have lived in Ranong for over five years. New arrivals continue to come in albeit at a much slower pace than in the past years. Over 55 % of the migrants live with their nuclear or compound families which have developed into several migrant communities in Ranong city. Only about 32% of the study respondents have a valid work permit and an equal number have temporary immigration cards; 27% of the respondents do not have any valid document. Unlike Sangkhlaburi where most of the migrants want to stay in Thailand, almost all migrants in Ranong intend to return home after they have saved some money to begin a new life in Myanmar. Thus migrants in Ranong are a mixture of both stable and transitory migrants whereas in Sangkhlaburi they are mainly stable migrants.

2 Gender and marital status

Like in many other parts of the region, women are generally submissive to men in the public and private power structures. Literacy rates are low, job and income opportunities outside home are low and access to information for women is limited. In Ranong, gender and marital status are among the main determining factors for the type of work and the salary. Women

consistently receive less salary than men even in similar occupations. These findings are consistent with other studies in the same population (Caouette T et al, 1999 draft). While men continue to enjoy access to commercial sex services, young women are coerced or forced into this sad situation. It is only natural that overall men have a better knowledge about HIV/AIDS than women. This, however, does not necessarily have much of an impact on their behaviour. While there are about 500 female sex workers, there are thousands of male clients for them. In many instances men do not protect themselves by wearing condoms and sex workers may be under pressure to not use them. The same men then return to their wives and girlfriends and engage in unprotected sex with them. It is a well known fact that men usually do not like to wear condoms with their wives or regular partners. They are the ones to usually raise the question of 'faithfulness' in an attempt to cover up their misdeeds. By raising awareness and understanding about HIV/AIDS among women means to constantly face the challenge of this power structure. These gender differences in sexual behaviour and acceptable norms have been clearly demonstrated in the study (section 3.8).

The power relation of men and women is also apparent in marriage. Men often take advantage of the subservient status of women when they are separated or divorced by separation or divorce. Once again, while men enjoy the advantage to find new partners or wives, women are hard pressed to care for themselves and the children who usually stay with them. In these compromised situations women are pushed into undesirable relations with other men or some time enter into commercial sex for much needed income. This has become apparent in Ranong where many single men have casual sex relations with widows and divorcees or wives whose husbands are away. About half of the sex worker respondents are also widows and divorcees. Last but not least, migrant women are also a target of physical and sexual violence by their fellow migrants and also Thai people and officials (Paul S et al 1997 and Couette T et al 1999).

3. Fisheries and 'fishermen culture'

Fishermen (35% of population) form the backbone of the migrant communities in Ranong. Together with the fishery related workers (17%) and family members (20%) they constitute over two-thirds of migrants in Ranong. Just under half of the fishermen are single who often stay together with friends or in a compound family. The rest stay with families and they lead a slightly different life. As stated elsewhere they have their distinct life style. Usually, they go out to sea for a few weeks to months and endure hard working conditions. Sexual activities on the boat are strongly discouraged because of the belief that this would bring bad luck such as breaking the net or boat, or not making a profitable return. Pornographic comics and nude calendars are allowed on board but masturbation is not. This norm of abstinence increases the pressure to have intensive sexual experiences when on shore. When they come to the shore they really crave for intense sexual release. One local expression says, 'upon landing fishermen are like mad dogs for sex'. Heavy drinking is very common among them and many would opt to visit a sex worker. In some fishing companies, entertainment is organised by the owner who pays a group bonus that involves drinking and visiting sex workers. Defaulters would loose their share if they do not join the group. This forces them to take part in the group activities sometimes termed as 'team work' by the boat owners. Condom use by the fishermen in commercial sex is still a problem. They are either not aware of the danger, or dislike condoms, or are too drunk to put them on. One recent survey on the Burmese

fishermen in Ranong and Samut Sakhorn shows 18% of them are HIV positive (Entz A. et al, 1998).

In addition, fishermen have some masculine practices which they believe increases their sexual prowess. *Fung muk* or implanting marble in the penis is becoming popular in recent years. It involves puncturing a hole in the foreskin or body of the penis and then inserting a marble in it. The cut skin is refolded, pressed tightly or bandaged for a few days. They also inject oil in the foreskin or shaft of the penis. In either circumstance they may share contaminated needles, blades or tools that increase their vulnerability to HIV infection. Overall, intensive sexual experience appears to be an important part of a fisherman's life and is one of the main topics of discussion among them.

4. Commercial sex

As stated earlier, there are about 500 sex workers in Ranong offering various forms of direct and indirect services and at least some of them belonged to the brothels evicted by a special police squad from Bangkok in 1993. They operate out of restaurants, beer bars, cafes, karaoke, saloon, guest houses and sometimes shadowy street corner. Most of them are concentrated in one particular location near the fishing piers. There are an estimated 350 women working as waitresses in 44 restaurants (WVT, 1998). Fourteen of the restaurants are known to provide direct services in their venue. The others range from indirect services that are freely available, to establishments where the women will only have sex with their boyfriends who may or may not be regular customers. In the latter case, some women often have more than one boyfriend and sometimes these boyfriends may fight among themselves to keep control of their relationship. Fishermen are the main clients in this area but there are other migrants and some Thai people. Considering the large contingent of 27,000 fishermen and half of them being single, there is a lot of demand for commercial sex. Ranong is also host to many other fishing vessels from outside. The area has rapidly developed since 1996 and on both sides of one street are numerous restaurants with lights and music and video screens, and many young women beckoning customers from the street. Most of the sex workers are Burmese and have been working there for varying periods of time ranging from less than a year to five years (section 3.10, commercial sex). Most of them are in the age bracket of 20-30 with a few older or younger. This is quite different from the past, where most of the girls in brothels were very young. About half of the girls interviewed in the study are divorcees or widows and one-third are married. This explains the helpless situation of migrant women where their husbands are not supporting them for a living who have either divorced or deserted them, or opted for a new wife. It was not possible to establish any link with trafficking and prostitution in the present circumstances which was so common in brothels of the past.

One interesting finding of the study is that sex workers have higher knowledge about HIV/AIDS than other occupational groups. Like many other similar situations, this increased knowledge did not appear to change their risk behaviours i.e. increased use of condoms or reducing drug use. About 60% of sex workers claim to have used condoms regularly with their clients but this has dropped to only 30% with their boyfriends and 10% with their husbands. HIV prevalence among migrant sex workers was also very high between 1992-94 when testing was done regularly along with the Thai sex workers. HIV-positive rates among migrants ranged from 50-65% at that time compared to 30-50% among the Thai sex workers.

Since then sentinel surveillance was done irregularly. In 1998, among a large number of indirect Myanmar sex workers, the HIV-positive rate was found to be 33.77%.

5. Drugs and substance use

Injecting drug use is prevalent in this population. Nine out of 436 respondents admitted to having taken IV drugs and six of them shared needles. Once again, most of these IDUs are fishermen or sex workers. IDUs are reportedly higher among Thai fishermen who were not interviewed in this study. Myanmar fishermen claim that although would like to take IV drugs, it is very expensive and beyond reach of many of them. So they rely on unknown cheaper substitutes but share needles. Some of the fishermen and sex workers also take other kinds of non-injectable drugs such as marijuana and amphetamines. Once again 250 baht for a pill of amphetamine is too much for them. So instead they use green or jade tablet often referred to as 'cough tablet' by ordinary fishermen. Although the details of the drug use are not fully investigated in this study, it safe to say that both IDUs and other drugs are present in this population and interventions should be instituted without further delay.

Myanmar fishermen are known for their high alcohol consumption which they attribute to their difficult life in Thailand often related to their illegal status. Usually they drink local Myanmar or Thai brand of beer or whisky. But sometimes they use some strong home made rice brandy which makes them drunk easily. Overall drugs and alcohol use are more common among Walat type of boats (see section 4.10) and uncontrolled alcohol consumption often leads to unprotected commercial sex. Fishermen are also strong believers of some of the myths described earlier such as drinking alcohol before and after sex will reduce the transmission of HIV so it is not necessary to use condom. All these practices once again increase their vulnerability to HIV/AIDS.

6. Knowledge and Misconception of HIV/AIDS

The misconception of HIV transmission and prevention is a serious problem among many people including migrants. Even some people who understand the methods of transmission still harbour the wrong perception that HIV is transmitted by casual contact such as touching, sharing house or toilets etc. In many instances, these misconceptions arise from rumours and hearsay from friends and peers about the disease. This also has something to do with the way HIV education campaigns are organised which stress the modes of transmission such as sex, drug use, blood transfusion or mother-to-child transmission and do not spend time to clarify about casual contacts such as touching, sharing house or office, sharing bathroom or toilet, using clothes or bed etc. The same applies to the knowledge of prevention which emphasises the use of condoms but not much discussion about the wrong perceptions people might have such as having sex with healthy partners does not transmit HIV, or HIV testing every three months can be a safeguards from the disease. This has created a 'half done' situation in Ranong, which can be very dangerous in some instances. These misperceptions are the root cause for the development of negative attitudes towards the PWHAs which often leads to their isolation, discrimination and abuses.

7. Rapid and slow transmission of HIV

There are two main patterns of HIV transmission in Ranong - (i) rapid transmission among sex workers and their clients, and IDUs. These groups have been recognised since the beginning of the epidemic in 1991. This trend still exists as a large number of sex workers continue to operate, albeit on different terms as there are more indirect sex workers today as compared to the past when there were more direct sex services in the brothels. IDUs and sharing needles is still a problem among fishermen and some sex workers; and (ii) slow transmission occurs among the general population through sexual contacts between regular partners and non-commercial casual partners. Slow transmission would most probably occur in married couples through unprotected sex where one partner has already contracted the virus from someone else. However, slow transmission is also possible among non-couples through casual sex relations and at least 25% of the study respondents have admitted to having had such relations in the last year. Unsafe sex vis-a-vis no use of condom is very common in non-commercial sex ranging from 98% in regular couples, 77% among boyfriend-girlfriends, 70% in casual sex, 70% of the sex workers with boyfriends and 90% of the sex workers with husbands.

The present commercial sex industry situation in Ranong is similar to many other cross-border locations such as in Mae Sot, Mae Sai, Khlong Yai and Nongkhai where migrant sex workers form a significant part. Condom compliance in commercial sex at Ranong is not so encouraging. Sixty percent of the sex workers claim to use condoms regularly, 37% sometimes and only 3.3% never. This finding differs from the clients of the sex workers, 28% of whom never use condoms, 16% sometimes and 56% always. According to recent HIV surveillance data, 38% of the indirect sex workers in Ranong (HIV/STD office, Ranong 1998). Thus rapid transmission through commercial sex is still a serious problem in Ranong but slow transmission through non-commercial sex is also thought to be widespread. HIV prevalence among ANC attendants in 1998 was 5.4% among migrants compared to 3.5% among local Thais (MOPH, 1998). This is a concrete example of severity of the HIV epidemic in the general population.

8. Health and HIV/AIDS services

Existing government health services generally provide emergency health care to all migrants. There are a number of problems for these services. Many migrants do not speak Thai or understand the Thai methods of treatment. These language and cultural barriers sometimes create misunderstandings between patients and hospital staff. Despite these problems, about 50% of the respondents rated health staff as good compared to 15% of the police and 23% of the general population. Another problem is that the hospitals do not have any special budget to care for the migrant patients. They therefore have to use their regular budget for the Thai population to treat migrants. In any event, government health services offer very limited activities for HIV/AIDS prevention and education among migrants.

In co-operation with the public health department, World Vision Foundation of Thailand (WVT) operates a clinic and outreach activities for HIV/AIDS prevention and care in several migrant communities in Ranong. Their project is based on a primary heath care concept, which provides comprehensive health services including reproductive health. In addition to treatment for common illnesses and reproductive health care, the clinic also provides

treatment for STDs. They also do HIV counselling and testing at the clinic. One of the most successful aspects of the WVT programme is that they have developed a strong community network in six of the Myanmar communities involving migrant volunteers and social workers. They have also built good working relations with the migrants housewives and their community leaders, and maintain good co-operations with some Thai community leaders, employers and local authorities in the close vicinity of the migrants.

Despite this apparent success with these migrant communities, the WVT project covers only a small segment (about 15%) of the migrant population in the province. Although some of the migrants outside their project area enjoy a few benefits from the project, it may be desirable to expand the WVT project or similar activities to the rest of the province. One particular concern of the WVT project is its economic sustainability as it requires outside funding to continue their activities. There were several local and central level discussions to make this project self-sustaining by raising local funds from the migrants and their employers. This issue should be discussed at the appropriate policy making levels and a decision should be made rather sooner than later.

Study Recommendations

The main purpose of this study is to provide an analysis of the HIV/AIDS situation of migrant and mobile populations in Ranong. In making recommendation one should bear in mind that the migrants live, work and interact with the local Thai people, their employers, health staff and police, immigration and other government officials. They understand their situations, organisational capacities and available resources. In many respects, these local agencies play a key role in the development of intervention programmes. It is therefore important that the following recommendations should be viewed as a guide for discussion with the (proposed) local and national working committee to develop strategies for intervention programmes in the area:

1. **Formation of a "local working committee" for migrant populations:** At the provincial level, a "local working committee" should be set up to coordinate activities related to the migrant workers. The main purpose of this committee will be to develop and/or improve HIV/AIDS and health services for the migrant population. This 'decentralised' committee should include but not be limited to representatives of the migrant community, relevant government agencies such as police and immigration department, health, labour and social welfare offices, NGOs and civil society groups. The committee should have a degree of autonomy to deal with local issues and should be allowed to raise local funding and use it for local purposes, and implementing necessary cross-border collaborations at the local level. The committee should be linked with and receive support from the provincial and central policy making bodies.

2. **Organisation of a local workshop:** As an initial stage for the formation of the proposed local committee as mentioned above, a workshop should be organised in Ranong involving all potential participants. The workshop could discuss the findings of this study and its recommendations as well as the structure, functions and funding of the committee. The committee and its partner agencies should then prepare a detailed work plan and implementation modalities of their proposed activities. This meeting will also be an important first step for the dissemination of the information to the local audience.

3. **Migrant People and community level:** Many migrants have been living in Ranong for several years and are concentrated in the migrant communities. Considering some short-comings, these communities have developed some systems of community organisations and activities with the support of WVT. Lessons learned from these community level activities as well as general strength of the communities could serve as a valuable asset for the strategies and approaches to the community level responses. Some specific recommendations for the community level activities are -

- **Peer education programme:** Assess and review WVT peer education programme in various population groups in Ranong e.g. fishermen, sex workers and housewives. If found successful, similar programme should be developed for other vulnerable population groups as identified by the study in Ranong (e.g. construction and agriculture workers).

- **Community mobilisation:** Review and assess the strengths and weaknesses of the community structure and capacities to undertake their own initiatives. There are encouraging examples of such activities in WVT project which should be shared with others. Similar activities should be initiated in the communities without such organisation.

- **Targeted interventions:** In some instances where peer education and community mobilisation are difficult to begin with, specific targeted interventions by outside agencies should start for these specific vulnerable groups e.g. new arrivals who are very vulnerable because of their ignorance about HIV/AIDS as well as living situations.

- **Focus on life-skills:** It has been found that increased knowledge does not always change behaviour e.g. sex workers and fishermen in Ranong. It is therefore imperative that HIV/AIDS projects should focus on creating understanding about vulnerability and correct methods for prevention and care. Participatory learning and activities (PLA) and other similar exercises with the people should be useful in some of these situations.

- **Gender sensitive approach:** It has been identified that the women have subservient roles in the community. They also have low knowledge of HIV/AIDS and are perhaps, inadvertently getting infected. All existing and future programmes should develop strategy that places equal emphasis on men and women so that they can make their own decisions. Programmes involving women and their leaders will help to achieve these objectives.

4. **Public health services:** It is acknowledged that the government health services have limited human and financial resources to deal with such a large number of migrants. Language barriers, hiring of staff and budgeting systems are just a few examples of their difficulties. In consultation with the local committees, the public health department should develop plans to resolve some of these issues through **public-private mix** management. For example they may raise local funds by implementing health card or social security schemes for workers, hire local bilingual interpreters through NGOs or private sector (WVT or Saphanplar State Enterprise).

5. **Programmes for Thai populations:** Public health office should take a note of the role and vulnerability of local Thai officials, people and businessmen in the commercial sex

industry in their area and develop appropriate awareness and prevention programme for the sex workers and their clients including Thais.

6. **NGOs programme:** WVT has been very active with the provision of services for the migrants in Ranong. In addition to running a clinic, they have done an effective job in facilitating the organisation of community level activities. Because of instability within the migrants' communities, they require constant supervision and readjustment. The following suggestions are made to improve efficiency and sustainability of the project - (i) in consultation with public health office and local committee, transfer the administrative responsibilities of clinic from the government to private sector. This will help to develop local management and financial systems for its self-sustenance, (ii) in consultation with the local committee and private sector (e.g. Saphanplar State Enterprise) develop an alternative private management system as suggested above. Involvement with the private sector will also help to improve working relations with migrant workers and their communities (details to be worked out locally), and (iii) in consultation with the local committee develop and implement a plan for the expansion of services to the other migrant populations in the district.

7. **Employer/private sector involvement:** Almost all migrant workers are employed in the businesses and industries run by the private sector such as fishing companies, production industries, construction companies, restaurant and entertainment owners. They should be actively involved in the discussions for health care strategies of their workers. In any such discussion with them one should be keep in mind to clarify profits to their individual businesses as well as labour and human rights issues (see details in section 3.12 and 4.12) Some of their possible involvement are outlined in the NGOs section above. Saphanplar State Enterprise and Thai-Myanmar Border Fishery Coordination Centre could play vital roles for successful health and HIV/STD programme for fishermen. It will also be important to involve Ranong Provincial Fishing Association, and boat and pier owners in any such schemes.

8. **Integration, not compartmentalisation of programmes**: The study identifies specific vulnerability of some migrant population groups. But any effort to promote HIV prevention in this population should disassociate HIV infection from at-risk groups (e.g. sex workers and fishermen) and focus on their risk situations. Programmes may still target those particular groups but careful attention should be given in the 'targeting process' that focuses on their behaviours, and ensure that the groups are not further stigmatised by the programme. As a way to avoid such critical issues it is desirable to develop programmes that address several population groups at the location and develop useful harmony among them.

9. **Cross-border collaboration between the opposing border towns:** There is existing cross-border collaboration between Ranong and Kawthaung mostly facilitated by WVT and WVM. Both World Vision staff and government health officials participate in these activities. It includes sharing information of communicable diseases including HIV/AIDS, development of IEC materials, referral of terminally ill migrant patients from Ranong to Kawthaung, participation in meetings on migrant population. There are some other areas where cross-border collaboration could be useful. However, such an approach should be as practical as possible so that the issues can be dealt effectively at the local level. Joint planning involving both sides of the border could be an ultimate goal but should only be pursued after small 'pilot' collaborations have proved successful. However, one should not overemphasise the importance of cross-border collaboration at this stage but wait for a suitable time and

opportunity by building trust and confidence among agencies working on both sides of the border.

10. Collaboration with the places of origin and destination of migrants: Many problems that the migrants face in Ranong are due to inaccurate information they receive before their departure. It will be very useful to explore the possibility of setting up programmes to disseminate information including HIV/AIDS to the potential migrants in Myanmar before they depart home. The scope of such programmes may be limited only to areas with large numbers of emigrants. In this approach the agencies in Myanmar will have the full range of information about problems in Thailand. In addition, they should also assess the needs and opportunities for projects to support these emigrant/returnee communities including PWHAs in the area.

11. Formation of national committee on migrant population: Similar to the provincial committees, a multisectoral committee should be formed at the central level to discuss the health and HIV/AIDS among migrants and in the border areas. Possible functions of the proposed committee are to develop strategic planning, technical support and fund raising for the projects to be implemented at the local level. This committee should also deal with the national level authorities to develop necessary policies on health care services for the migrant populations. Policies should be clear, precise and practical so that they are easy to implement at the provincial and district levels. These policies should become an integral part of the overall policies on migrant populations in the country.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

CHAPTER V

SUMMARY OF THAI-MYANMAR BORDER SITUATION

About 2,400 kilometre long border between Thailand and Myanmar stretches from the infamous 'golden triangle' in the north to Victoria Point or Kawthaung in the south. Most of the border area is covered by forest and mountains and are inhabited by various ethnic minority populations e.g. Mon, Karen, Kareni and Shan. Most of these minority groups are opposed to the Myanmar government and have waged political and armed struggle for wider autonomy or outright independence. The Myanmar government is actively suppressing these uprisings and political persecutions are widely reported from various areas. As result of these conflicts many ethnic minorities have moved to the border areas and are living in several refugee camps. In recent years, because of constant attacks by the Burmese military, most of the refugee camps have moved inside Thailand.

At the same time, because of political isolation and trade embargoes imposed by the outside world, there has been continuing deterioration of the Myanmar economy. Universities have been closed for over eight years. Students and young people do not have the opportunity for higher education nor productive employment. On top of this, the government and local authorities continue to impose taxes on people which makes their life more and more difficult. As a result of these complex socio-political and economic constraints, thousands of Burmese people are also coming to Thailand in search of political asylum, jobs and income.

Due to the difficult terrain and thick forest, as well as long standing political differences between Thailand and Myanmar, roads and transportation infrastructure are generally poorly developed in the border areas. At present there are four major border crossing points, from north to south they are - (i) Mae Sai-Tachilek, (ii) Mae Sot-Myawaddy, (iii) Sangkhlaburi-Phyathongsu or Three Pagoda Pass, and (iv) Ranong-Kawthaung. In addition there are many other smaller border crossings in several provinces. But the whole border is porous and usually not so rigidly monitored by either countries, which allows for a continuous flow of people.

So many areas on the Thai-Myanmar border have become a mixture of refugees, political activists, local villagers and migrant workers. There are also many traders, tourists and visitors of both countries which vary from place to place. The upper Thai-Myanmar border is also known for its notorious opium producing 'golden triangle' and drug trafficking routes at various points. In recent years other drug production facilities such as methamphetamine and ecstasy have reportedly move from Thailand to the hidden areas inside Myanmar. In addition, this border has been the focus for the trafficking of girls and women for sex work mostly from Myanmar but also from China. Even now Mae Sai, Mae Sot and Ranong have a large number of Myanmar sex workers but it is not very clear if any of them are victims of recent trafficking or not. What is known though is that some of them were trafficked to the brothels in the past and following closure of the brothels many could not find alternative ways of living and stayed on in sex work. At present most of the sex workers have freedom of movement and it appears that they are 'voluntarily' working in this business. It is therefore very important to understand the unique background of the Thai-Myanmar border and each of the two study sites i.e. Sangkhlaburi and Ranong in the context of HIV risk situations.

Sangkhlaburi is a relatively quiet border crossing with a strong mixture of refugee and migrant populations most whom belong to two ethnic minorities i.e. Mon and Karen. Most of the migrants here have settled for some time and they have minimal mobility in and out of the area. Some of them have friends and relatives who have received Thai nationality. In general, most of them do not intend to return to Myanmar and are seeking permanent residence in Thailand. All refugees belong to the ethnic minority groups and are expected to return home after a political settlement in their home states. The other group of migrants who go to work in central Thailand, are a mixed bag. While some of them return with good income others are arrested and deported by the Thai authorities. But in general, they intend to return home. Sangkhlaburi is not an active business area nor a popular sex tourist destination. As a result, it has a very diminutive sex industry and most of the clients are Thai uniformed men and officials, traders and wealthy residents.

Ranong is a unique sea-border crossing between Thailand and Myanmar. It is famous for its well developed fishing industry and plantations both of which are labour intensive. Its own population is insufficient for local labour needs and this has resulted in migration of labour from other places mostly from neighbouring Myanmar. Today, 77,500 strong migrants marginally exceed the number of the local population (72,361) in the Muang district where local economy and the social life are mixed with the migrants. A large proportion of these migrants work in fishing and related industries. Many of them have come to Ranong along with their families and formed several migrant communities. In general, the migrants' life style in Ranong is heavily influenced by the fishermen which includes rough social encounters, heavy drinking and sex ventures including commercial sex. Another group of Myanmar migrants transit through Ranong to central or southern Thailand. But all in all most migrants here intend to return home. There is a very large sex industry in Ranong and most of the sex workers are from Myanmar. Migrants are their main clients but there are some Thai people too. In addition, unsafe casual sex among migrant men and women in Ranong is prevalent; this is related to their unique life style, living conditions and socio-economic situations. Drug use including IDUs is still prevalent among fishermen and sex workers. Drug use is reportedly more prevalent among Thai fishermen.

Comparison between Ranong and Sangkhlaburi

Figure 3.20 provides a quick comparison of the migration and HIV/AIDS risk situations, and health and HIV/AIDS services in Ranong and Sangkhlaburi. These differences illustrate the uniqueness of the situations at each border crossing which should be given a careful consideration for the analysis of HIV/AIDS vulnerability and subsequent project formulation in these border areas. The following analysis of some of the key issues are given special emphasis in this study and are used a basis for general recommendations in the report.

Population migration is dynamic in Ranong involving a very large number of people i.e. about 77,500 in Muang district. In addition, thousands of others stay a short time in Ranong and then travel to central and southern Thailand. Thus, there is a mixture of both transient and stable migrants. In comparison, in Sangkhlaburi there are about 20,000 migrants in the district. About 15,000 Mon and Karen refugees in several camps along the border. There are also some migrants who travel from border locations to central Thailand. Many of the latter groups are arrested en route or at the destinations by Thai authorities and deported back to the border. So in general, migrants in Sangkhlaburi are not too much involved with the

Figure 3.20: Comparison Between Ranong and Sangkhlaburi

ISSUES	SANGKHLABURI	RANONG
Migration situations		
Geographical location	Difficult forest and terrain	Sea border crossing
Size of population	Estimated 20,000	Estimated 77,500
Ethnicity	Mostly Mon and Karen	Mostly Burmese, some Mon
Reasons for migration	Ethnic conflict and economic	Mainly political & economic
Mobility pattern	Mostly slow movement	Mixed slow and rapid
Length of stay	Mostly long-term	Short and medium
Main occupation	Agriculture	Fishing and fishery related
Accompanying family	Mostly with family	Both single and married
Legal status	Illegal but long-term pass	Illegal and temporary pass
Relation with Thai people	Close with Thai people	Not close, stay separate
Intentions to return home	Intend to stay in Thailand	Intend to return to Myanmar
HIV risk situations		
Overall knowledge of HIV	Poor in almost all groups; Mean score is 0.4054	Good but not in all groups; Mean score is 0.5241
Knowledge and gender	Very low in women	Low in women
Knowledge and occupation	High in factory worker; low in agriculture workers and fishermen	High in sex workers and fishermen; low in construction workers
Commercial sex	Small sex industry; migrant sex workers mostly Thai clients; rarely migrants	Large sex industry; many migrant sex workers; mostly Myanmar clients; few Thai
Casual "non-couple" sex	Prevalent among many	Prevalent among many
Prevention by condom use	Seldom used	Only sometimes used
Drugs and IDUs	Occur in general population	Prevalent in certain groups e.g. fishermen & sex workers
STDs prevalence	Insufficient data, prevalence not so clear	Decreasing from very high rates; but still prevalent
Misperceptions of AIDS	Many misperceptions	Improving but still common
Attitude towards PWHAs	Strongly negative	Improving in some groups
Overall risk situations	Lower but significant risk	Very high risk situations
HIV prevalence	Insufficient data	High in the groups tested
Health care services		
General treatment	Mostly public and NGOs, few private	Mixed public, NGOs, private and self-treatment
Maternal and Child Health Care (MCH)	Available in the hospitals and clinics;	Available in WVT clinic and some outreach communities
Reproductive heath	Low knowledge and use	Not so widely used
STDs treatment	Insufficient data	Available in WVT clinic
HIV/AIDS education	Low priority in most cases	Good in some communities
Condom provision	Scarce and not popular	Inadequate and not popular
HIV counselling and testing	Limited availability	Generally available - WVT
Care of PWHAs	Very limited to non-existent	Gradually developing

transitory migrants and live in the stable communities in and around Thai villages. It is also a fact that the Mon and Karen have closer cultural links with Thai people and often receive favourable treatment in Thailand. The predominantly Burmese migrants in Ranong have historical and cultural differences with Thai people and they usually receive a cool reception from the authorities. As a result, migrants in Ranong tend to live in the 'patchy' migrant communities clustered in the overcrowded port area.

Legal status of migrants is a serious concern in Ranong and to a slightly lesser degree in Sangkhlaburi. It affects their mobility, job opportunities, salaries and benefits, social security including access to health care and living situations. As most of the migrants are illegal in Ranong, they are at the mercy of their employers and often receive salaries lower than the minimum wage or the Thai labours doing the same jobs. They also do not get any other benefits such as health or social security services. Illegal migrants are also a target of immigration and border police crackdowns and there are many reported cases of exploitation and abuse in the hands of police. In the past the Thai government had made several attempts to regularise the legal status of migrant workers through registration and issuance of work permits but met with only partial success, mostly because of lack of co-operation from the employers to register their workers. According to those policies, the employers stood to lose a lot if they would register their workers because they had to pay registration fees, health check-up, social security scheme or health card etc. So the legal status of the migrant workers in Ranong and the rest of Thailand remains an unresolved issue and there is no clear sign of improvement in the near future. Although most of the migrants in Sangkhlaburi are illegal, they usually do not face the same problem as Ranong. In Sangkhlaburi, the immigration office issues pink, orange or blue cards to categorise their legal status (section 3.1) which serve as a permit to live and work in Thailand. Nonetheless, legal status of the migrant workers is a single most important issue for their economic and social well-being. It is also a great challenge to the Thai government to develop internationally accepted labour standards and migration laws.

Migrant communities exist in both Sangkhlaburi and Ranong. As stated earlier, these communities in Sangkhlaburi are located in the Thai villages or in their close vicinity. With the exception of some remote areas where migrants live in the farm houses, most migrants here have usual rural community structure and activities. Many of the local Thai villagers belong to Mon and Karen ethnic groups and mix easily with members of their same ethnic group. Mon have their temples (*wat*) and the monks provide them with moral and spiritual guidance. They also organise traditional festivals and *wat* activities, and other community development initiatives. So the migrant communities here have some cohesion and strengths that could be useful for the community based activities including HIV/AIDS programme. Predominantly Christian Karen have their own community in the district supported by Christian charities and organisations which can also be used for community based activities.

In comparison, migrant communities in Ranong are relatively unstable because of the illegal status of migrants, constant turnover of their inhabitants, and lack of cooperation from their Thai neighbours. The cohesion and strength of these communities are weak and they are usually reluctant to initiate community level activities by themselves. Local Thai people are not so interested to help them to settle properly. So the migrant communities still require constant outside encouragement for any community based activities. Nonetheless, because of the consistent community based programming WVT has brought together some Thai community leaders to work with the migrants e.g. Paknam area. But cooperation from the

immigration police and other law enforcing authorities are still far from satisfactory which is at least in part due to an absence of a clear government policy toward migrants. Police and other law enforcing authorities are concerned with the immediate threats to the national security and social problems created by the migrants such as robbery, drug smuggling, potential transmission of communicable diseases and deteriorating hygiene and sanitation situations. Some officials are also concerned that if the migrants are allowed develop well organised communities, this may act as a strong 'pull factor' for the influx of more migrants and in the long run it will be difficult to send them back to their country.

So this is a real dilemma in the mind of many Thai people and authorities that as long as the migrants are in Thailand, how far they should go to create an 'enabling environment' for their living and social support system. If they do too little, it shows lack of compassion and denial of basic human rights. This may contribute to the vulnerable environment for local Thai people too such as outbreak of epidemic diseases or criminal activities. On the other hand if they allow the development of strong migrant communities, this may become a strong 'pull factor' for more migration and a serious deterrent to their eventual repatriation back home. So it is imperative that one should try to find a 'balanced formula' to address these two contrasting interests and facilitate creation of an enabling environment for the care and support of the migrant people in the country.

HIV risk situations: There are significantly different pictures of HIV transmission in Ranong and Sangkhlaburi. In Ranong there are two main patterns of HIV transmission - (i) rapid transmission through commercial sex among sex workers and their clients, and IDUs. While most of the sex workers and their clients are Burmese, there are also significant numbers of Thai people e.g. fishermen, truck drivers and other people visiting the sex workers, and (ii) slow transmission among general population through casual and regular partner sex. While the former had a very prominent role in the transmission of HIV in the past and still does to a large extent, the latter has become increasingly important in the present circumstances. In another words, the extent of 'unsafe' casual partner and regular 'couple' sex are sufficient to keep the momentum of HIV/AIDS epidemic going for some time. So it is important that any existing and future HIV programme in Ranong addresses both of these transmission patterns. In comparison, Sangkhlaburi has a relatively small commercial sex industry and most of the clients are Thai officials, traders and wealthy local residents. Few migrants can afford to visit such places. However, a significant number of migrants are involved in 'unsafe' casual sex among themselves, sometimes with the migrants from other places and so on. There are also some IDUs in the migrant community. So it can be concluded beyond doubt that there is a slow HIV transmission of HIV in this population and they are certainly not out of risk. These findings are also supported by the limited HIV testing data available from the local hospitals which shows HIV-positive people among the patients. So HIV prevention programme should begin in these communities without any further delay and hopefully the situation can be contained at this early stage.

Health and HIV/AIDS Services:

In **Sangkhlaburi**, all general health services are available for the migrant people most of whom go to the government hospital and clinics and some of them to the private missionary hospital or CMH (section 3.8). Because of the closer cultural ties with Thai people, most of the migrants say they have no problem with the Thai hospital, a few complain about high costs and others cite language problem. CMH plays an important role in the heath care of the

migrants and refugees in the area. This hospital specially favoured by the Karen Christians and people who do not speak Thai well. They also have some special services for the migrants e.g. rehabilitation centre for the physical and mentally disabled people. Neither district health office nor CMH has any organised program for HIV/AIDS education in the area but are considered to be in good position to do so. While MSF and ARC are not involved in services for migrants in Sangkhlaburi, they have an important role in the health care of the refugees in the camp including deported or repatriated migrants from central Thailand. They also act as a bridge between both sides of the border and are important link with the Mon and Karen social organisations active in the border.

In comparison, the access to public health care system **in Ranong** is a problem for many migrants. Illegal status, language barriers and high cost of treatment make it difficult for them get services in Thai hospitals. While emergency medical services are generally available, preventive care including HIV/AIDS services are inadequate. Because the hospital does not have any special fund for the migrants, usually they share Thai patients' budget for the care of large number of migrants. WVT in collaboration with the public health department runs a clinic near the port area. They provide OPD services, diagnosis and treatment for STDs and counselling and testing for HIV. In addition, they organise community based programme including HIV/AIDS education and other activities in six communities (pop. 15,000). After about five years in operation, they are still struggling with some of the major issues such as dependence on outside funding, lack of private sector (employers) involvement and expansion of activities to the remaining 62,500 migrants in Ranong. Private sector businesses that employ the migrant workers are not involved in the health care or social securities of their employees. Some of them are however showing interest in these activities, which should be pursued at all levels, e.g. Thai-Myanmar Fishery Coordination Centre and Saphanplar State Enterprise, boat and pier owners etc.

General Recommendations

Understanding the local situation of HIV/AIDS and the perspectives of the local agencies - government, NGOs, private sector and the civil society in general - are very important in making recommendations for each of the sites. Bearing this in mind site specific recommendations are provided at the end of each chapters III and IV (see sections 3.12 and 4.12). The following are some of the recommendations that in addition to their relevance to the study sites have much wider implications for similar cross-border locations or migrant populations in general, and for the development of national level strategy and co-ordination of intervention activities. In other words, these recommendations are based on a broader scope that goes beyond these study sites and looks at more general influences on migrant and mobile populations and possible outcomes.

1. **Improving legal status:** Illegal status of the migrant workers is one of the main obstacles to the development of health services for the large majority of migrants in Thailand (section 3.11 and 4.11). This affects their access to health care, social network with fellow migrants and relations with local Thai population. Because of this, they also do not invest for the long-term benefits and are not so interested to contribute to the development of their communities. The Thai government should take concrete measures to regularise migrants' registration and employment conditions. The regularisation process should also include provision for health care and social support systems such as social security schemes

or health cards as appropriate. Once a set of clear policies are developed they should be enforced vigorously to give full benefits to those who abide by them. Without a clear policy on migrant labours and improvement of their legal status, it is almost impossible to develop stable and satisfactory services for them in the country.

2. **Creation of an 'enabling environment':** Cross-border locations often have their unique administrative and economic power structures. Local immigration and border police, military and governor's office play a crucial role in determining the status and treatment of the migrants in their area. In most instances, these local officials may have 'privileged knowledge' and perhaps interests in some local businesses including commercial sex and drugs. With their tacit support migrant sex workers are brought or trafficked into the venues. Some local officials are also known to patronise them quite regularly. So in the guise of doing their job to solve problems they actually become part of it. It is therefore of utmost importance that these law enforcing authorities be brought to the tasks so that they work with the health department, NGOs, private sector and all of civil society to create an enabling environment in support of the migrants. While this may appear to be a very far reaching strategy, it however is expected to provide sustainable results in the long run and should therefore be tried in a few 'pilot' sites.

3. **Public Health Services:** Government health services have limited resources to cope with large numbers of migrants. Migrants face language difficulties, relatively high costs, and for other reasons the quality of service is often inadequate. In consultation with the local and national committees the public health department should examine these issues and seek solutions. As stated above there must be systems in place to provide basic health services to all registered migrant workers. This could be undertaken by raising local funds through health cards or a social security scheme for registered workers. Funds could support such activities as hiring local bilingual interpreters seconded from the NGOs or the private sector to work in hospitals or public health facilities.

4. **Programme for Thai populations:** MOPH should take a note of the Thai uniformed men, local officials' and other people's involvement in the commercial sex industry in the border areas. In some border locations, mobile Thai people such as truck drivers, fishermen, traders and tourists and visitors are the main clients in commercial sex and perhaps drug use. Public health offices and local committees should develop appropriate awareness and prevention programmes for these vulnerable people especially uniformed men as well the sex workers who provide services. In dealing with the non-Thai speaking Myanmar sex workers, it might be useful to involve an NGOs or private sector with trained multilingual staff.

5. **Developing monitoring and evaluation tools for border programmes and migrant population:** Border programmes are usually expensive because of geographical remoteness of the areas as well as the extent of resource mobilisation required. Unlike HIV/AIDS programmes with native stable communities in a country, these programmes deal with mobile populations and/or relatively unstable communities. There has been considerable debate as to what to expect from these border programmes or to be precise what are the monitoring and evaluation indicators one should use to measure the progress in the projects. Some findings of this study will help but additional research may be necessary to develop effective monitoring and evaluation tools for these kind of programmes.

6. **Mass media programme for the border population**: Many local and migrant people in the border areas do not have a clear knowledge of the disease and health risk they are facing. For example, Thai travellers or visitors going to Ranong may be exposed to malaria or filariasis. On the other hand, Burmese migrants coming to the border may be exposed to HIV/AIDS/STDs, accidents or violence. It will therefore, be an important step to initiate good mass media programmes such as television and radio programme, to disseminate information to people on both sides of the border. As a part of the proposed mass media programme, local and national committees on migrant labour should also brief and guide national and international media for proper reporting on sensitive issues involving migrant populations.

7. **Advocacy for migrant workers:** The local and national committees should raise awareness about migrant and mobile population issues with government officials, NGOs, mass media and the general public. They should provide detailed facts about migrant workers role in the local and national economy and their social consequences. In this way they could contribute to the development of a positive environment regarding the presence of migrants in the country as well as helping to alleviate some of the existing negative image about them.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

REFERENCES

Abdool Karim Q. et al. Seroprevalence of HIV infection in South Africa. AIDS 1992, 6:1535-1539.

Agarwal A. et al. Halting AIDS on Highways: A unique initiative of transport corporation of India - A transport business group in India. XI International Conference on AIDS. Vancouver, July 1996, [abstract Th. C.4830].

Anderson RM. The spread of HIV and sexual mixing patterns. In Aids in the World II. Edited by Mann J, Tarantola D. New York : Oxford University Press, 1996: 71-86.

Appelyard RT. International migration: Challenge for the nineties. Geneva: International Organisation for Migration, 1991.

Archavanitkul K et al. A study of Interest Parties, Legal Issues and the State Management System. In the National Seminar on Policy Options of Importation of Foreign Labourers into Thailand, Bangkok. 1997

Asia Watch. A Modern Form of Slavery: Trafficking of Burmese Women and Girls into Brothels in Thailand. 1993.

Asian Harm Reduction Network (AHRN). The Hidden Epidemic: A Situation Assessment of Drug Use in South East and East Asia in the Context of HIV Vulnerability. 1999.

Asian Research Centre for Migration/SEAMEO-TROPMED/WHO/GTZ. Second Technical Consultation on Transnational Population Movement and HIV/AIDS in Southeast Asian Countries. Report. May 1997

Asian Research Centre for Migration/WHO. Report of Technical Consultation on Information Regarding Population Movements and HIV/AIDS. Report. May 1995

Bennet T. "An Aura of Risk". In: Second Technical Consultation on Transnational Population Movements and HIV/AIDS in Southeast Asian Countries, Chiang Rai, Thailand. Seminar Proceedings. Asian Research Centre for Migration. May 1997

Bessey A. Final Evaluation Report for the Thai-Myanmar HIV/AIDS Border Project of World Vision Foundation of Thailand. April/May 1998.

Bhoruka Public Welfare Trust, India and General Welfare Pratishthan, Nepal. STD/HIV/AIDS Cross-border Intervention Workshop - Sharing the India-Nepal Experience. December 1996 and April 1997

Bollini P. and Siem H. No real progress towards equity : Health of migrants and ethnic minorities on the eve of the year 2000. Soc. Sci. Med. 1995, 41(6):819-828.

Borjas, G.J. Economic theory and international migration. International Migration Review, Special Silver Anniversary Issue 23(3),1989.

Brewer T. et al. Migration, ethnicity and gender : HIV risk factors for women on the sugar cane plantations (bateyes) of the Dominican Republic. XI International Conference on AIDS. Vancouver, July 1996.

Bronfman PM and Rubin-Kurtzman J. Two borders, one country : sexual behaviour of migrants and HIV risk practices at Mexico's southern and northern borders. XI International Conference on AIDS. Vancouver, July 1996.

Caouette, T et al. Assessment of Reproductive and Sexual Health Perspectives, Concerns and Realities of Migrant Workers in Burma and Thailand (Draft). Institute for Population and Social Science Research, Mahidol University, Thailand. 1999.

Castello-Freeman, A.J. and Freeman R.B. When the minimum wage really bites : The effect of the US-level minimum wage on Puerto Rico, in Bodas and Freeman (eds.). Immigration and the Work Force : Economic Consequences for the United States and Source Areas. Chicago : University of Chicago Press, 1992, pp.177-212.

Chaelemwong Y. A Estimated [sic] Undocumented Migrant Workers in Thailand. Thailand Development Research Institute, Bangkok. 1996.

Chantavanich, Supang. Thailand's Responses to Transnational Migration during Economic Growth and Economic Turndown, Sojourn 14:1, pp 159-77, 1999.

Chintayanond S. et al. The Monitoring of the Registration of Immigrant Workers from Myanmar, Cambodia and Laos in Thailand. Asian Research Centre for Migration, Chulalongkorn University, Bangkok 1997.

Decosas J et al. "Migration and AIDS". The Lancet. 1995; 346:826-29

Decosas J et al. Migration and HIV. Montreal, 1996.

Division of Epidemiology, Ministry of Public Health, Thailand. HIV Sentinel Surveillance in Thailand by Province. 1989-98.

Entz, A. Risk Factors and HIV Prevalence among Fishermen in the Gulf of Thailand and the Andaman Sea, presented at the Seventh National Seminar on HIV/AIDS, Bangkok, April 1999.

Family Health International - Asia Regional Office (Bangkok). Strategic and Implementation Plan for Lao PDR. Assessment Report. September 1994

Family Health International - Asia Regional Office (Bangkok). On the Need for a Regional Strategy for Cross-border interventions to Reduce Transmission of HIV in Asia. Unpublished Monograph. July 1996

Family Health International - Asia Regional Office (Bangkok). A Regional Cross-border HIV/AIDS Prevention Response in East Asia: Seminar Proceedings. AIDS Prevention Monograph Series Paper No.2. January 1996

Family Health International. Making Prevention Work: No.10. Crossing Borders - Reaching Mobile Population at Risk. May 1999.

Fernandez I. Migration and HIV/AIDS. In: 4th International Congress on AIDS in Asia and the Pacific in Manila. October 1997

Hendricks, A. AIDS and Mobility. Copenhagen : WHO Regional Office for Europe,1991.

Kanchanaburi Provincial Statistical Office. Statistical Reports of Changwat Kanchanaburi. National Statistical Office, Office of the Prime Minister. 1997 Edition.

Kelly P. Managing HIV Vulnerability of Mobile Populations: Methodologies for Data Collection. In: Satellite Symposium, 4th International Congress on AIDS in Asia and the Pacific in Manila. October 1997

Kouame K. Migrations et prostitution dans la region d'Abidjan. In Actes du Symposium 'Sida et Migrations' dans le cadre de la VIII Conference internationale sur le Sida en Afrique, Marakech 1993. Edited by Kane F, Trudelle M. Quebec : Centre de Cooperation Internationale en Sante et Developpement, 1994:32-42.

Kravitz JD, Mandel R, Petersen EA, Nyaphisis M and Human D. Human immunodeficiency virus seropevalence in an occupational cohort in South African community. Arch Itnern Med 1995;155(15):1601-1604.

Leaune V. and Adrien A. Evaluation of a pilot project designed to provide HIV prevention on boats from France to Morocco and Tunisia : data analysis. Montreal : McGill AIDS Centre, December 1996.

Massey D., Arango, J., Hugo G., Kouaouci, A., Pellegrino, A. and Taylor, J. An Evaluation of International Migration Theory : The North American Case, Population and Development Reviews 20(4) 1994, pp. 699-751.

McKaig C. Regional study on AIDS and migration in the Sahel. Report of workshops held in Niamey, Niger, 18-19 February 1992 and Bamako, 21-22 February 1992. Niamey, CARE International/CARE Niger, 1992.

Mishra S. I et al. AIDS Crossing Borders: the Spread of HIV Among Migrant Latinos. West View Press, Oxford, 1996.

Muliawan P et al. STD/HIV/AIDS education, condom PR motion/distribution, and STD services for truckers in Bali, Indonesia. XI International Conference on AIDS. Vancouver, July 1996.

Oppenheimer E et al. HIV/AIDS and Cross-border Migration: A Rapid Assessment of Migrant Population Along the Thai-Burma (Myanmar) Border Region. Asian Research Centre for Migration. January 1998

Painter TM. Migration and AIDS in West Africa : A study of migrant from Niger and Mali to Cote d'lvoire: Socio-Economic context, features of their sexual comportment, and implications for AIDS prevention initiatives. New York : CARE International, 1992.

Paul S.R. et al. Reproductive Health Survey of Migrant Burmese Women in Ranong Fishing Community, Thailand. In: 12nd World Conference of the Society for International Development in Santiago, Spain 1997.

Paul S.R. HIV Seropravalence in the Border Provinces of Thailand: a Macro-analysis. (unpublished data) Asian Research Centre for Migration, Chulalongkorn University, Bangkok 1996.

Paul S.R. Dual Problems of HIV/AIDS Among Illegal Migrant Labourers in Thailand. In: 4th International Congress on AIDS in Asia and the Pacific in Manila. October 1997.

Piore, M. Birds of Passage : Migrant Labour in Industrial Societies. New York: Cambridge University Press, 1979.

Porter DJ. Wheeling and Dealing: HIV and Development on the Shan State Borders of Myanmar. United Nations Development Programme, New York. Study Paper. 1995.

Pramualratana A et al. Assessment of the Potential for Spread and Control of HIV Among Cross-border Populations Along the Thai-Cambodia Border. Institute for Population and Social Science Research, Mahidol University. Monograph. June 1995

Quinn TC. Population migration and the spread of types 1 and 2 human immunodeficiency viruses. Proceedings of the National Academy of Sciences 1994, 91:2407-2414.

Ranong Provincial Statistical Office. Statistical Reports of Changwat Ranong. National Statistical Office, Office of the Prime Minister. 1998 Edition.

Sakboon M. On the Frontier of AIDS Transmission. *Nation*. 16 June 1997

STD/HIV Report, Provincial Health Office, Ranong. 1998

STD/HIV Report, Provincial Health Office, Kanchanaburi. 1998

Stern A et al. Maps of International Borders Between Mainland Southeast Asian Countries and Background Information Concerning Population Movements at the Borders. Asian Research Centre for Migration. February 1998.

Thailand Seafarers Research Team (UNAIDS/UNICEF coordinated). Profiling the Maritime Industry and Responses to HIV and Drug Use Among Seafarers in Ranong, Thailand. Undated (?1999).

Thailand Seafarers Research Team (UNAIDS/UNICEF coordinated). Profiling the Seafarers Source Communities and Responses to HIV and Drug Use Among Seafarers in Northeast Thailand. Undated (1999).

The Netherlands Institute of Health Promotion and Disease Prevention. AIDS & Mobility Project Guide, Projects and organisations addressing HIV/AIDS prevention for mobile population in Europe. Amsterdam, Netherlands, June 1996.

Wolffers I et al. Migration and AIDS (letter). Lancet, 1995, 346:1303.

Wolffers I et al. Migration and HIV/AIDS in Southeast Asia: Initiatives for New Research and Intervention Approaches. In: 4th International Congress on AIDS in Asia and the Pacific in Manila. October 1997.

APPENDIX

INTERVIEW QUESTIONNAIRE

This questionnaire covers all the questions used in all four sites – two sites in Cambodia and two in Myanmar. Not all questions were used in each site as the questionnaire was modified to suit the different conditions in each site, thus the order may not always be as it appears here.

Interviewer ___________ Interpreter ___________ Questionnaire inspector/reviewer_______
Province ____________ District ____________ Sub-district
_________Village__________
Place/Area ________________
Date and time of interview : Date: _____/__________/_______ Time: _____________

PART ONE: DEMOGRAPHIC DATA

1. age ______________ year
2. gender ❐ male ❐ female
3. marital status ❐ single (skip to 4) ❐ married ❐ divorce ❐ widow
   3.1 spouse is ❐ Thai ❐ Migrant
   no. of children ________________
   no. of children born in Thailand ____________
4. education ❐ no education ❐ _____ years of education
   ❐ others ______________________________
5. major and secondary occupations in Thailand (put no 1 for major and 2 for secondary job)
   ___ agriculture ___ fishermen ___ related to fisheries
   ___ construction ___ water transportation ___ production
   ___ services (hotel, restaurant, maid) ___ commercial sex worker
   ___ labourers or vendor ___ timber factory ___ run a shop/trader
   ___ no job ___ other (specify) ____________
6. ethnicity ❐ Burman ❐ Mon ❐ Tavoy
   ❐ Karen ❐ Khmer ❐ Lao
   ❐ Vietnam ❐ other (specify) __________
7. religion ❐ Buddhism ❐ Christianity ❐ Muslim
   ❐ others (specify) ______________________________
8. Thai language ability

	Good	Moderate	poor	not at all
write	❐	❐	❐	❐
read	❐	❐	❐	❐
speak	❐	❐	❐	❐
listen	❐	❐	❐	❐

PART TWO: MIGRATION PATTERN

Pre-departure

9. What did you do before coming to Thailand?
   ❒ no job ❒ student ❒ factory ❒ agriculture
   ❒ CSW ❒ labourer ❒ fishermen ❒ trade
   ❒ services (domestic work, restaurant) ❒ others specify ____________

10. Who suggested/facilitated you to come here?
   ❒ myself ❒ friend ❒ relatives ❒ employer
   ❒ Thai recruiter ❒ Burmese/Khmer recruiter ❒ other specify ____________
   (please tell steps of facilitation ____________________________)
11. In case a recruiter facilitated you, how much did you pay to come?
   ❒ no payment ❒ pay ____________ baht
12. Did you have any prior information on the border area/Thailand?
   ❒ don't know ❒ know from ____________________
13. Did people in your neighbourhood also come to work here?
   ❒ don't know ❒ nobody ❒ yes, a few because ____________
   yes, a lot because ____________
14. Did your neighbours go to other countries apart from Thailand?
   ❒ don't know ❒ no ❒ yes, go to ____________________
15. Where is your hometown? ________________________________
16. Apart from living in your hometown, have you migrated to other places?
   ❒ no
   ❒ yes. 1. town/division/state ____________ for how long? ________
   Reason for migrating ____________________________
   2. town/division/state ____________ for how long? ________
   Reason for migrating ____________________________
   3. town/division/state ____________ for how long? ________
   Reason for migrating ____________________________
17. What is the major reason for coming to stay here?
   ❒ for job ❒ escape from fighting ❒ join family/relatives
   ❒ escape military/labour draft ❒ others specify ____________

Travel to Thailand

18. When did you first arrive here (how many years/months)?
   ____
19. For this time, how long have you been working here?
   ____________ years/months
20. Before coming here, have you worked in other places in Thailand?
   ❒ only work here for the first time ❒ only work here, this is the ________ time
   ❒ used to work in province ____________ for __________ years/months
21. Do you have travel costs to cross border?
   ❒ no ❒ yes amount ____________ Baht/day/trip for
   ❒ bus fare ❒ boat fare ❒ immigration fee ❒ other specify ________

22. What check points do you pass? (multiple responses possible)
    ❒ no check point (skip to 25) ❒ Burmese/Cambodian checkpoint ❒ Thai checkpoint
    ❒ others specify ______________________
23. If you pass checkpoints, what kind of document you hold?
    ❒ border pass ❒ passport
    ❒ immigration card ❒ migrant work permit registered by employer
    ❒ others specify ______________________
24. Do you have an ID card?
    ❒ yes ❒ no why? ______________________
25. What kind of card (document) you got from Thai authorities?
    ❒ no document ❒ work permit ❒ border pass ❒ passport
    ❒ immigration card ❒ other specify ______________________

26. Does your card expire now?
    ❒ yes ❒ no

Type of housing

27. What kind of housing do you have?
    ❒ stay with employer ❒ stay in employer's housing
    ❒ stay in Thailand, far from community ❒ stay in migrants' community
    ❒ stay in Burma/Cambodia ❒ stay in vessels
    ❒ other specify ______________________
28. With whom do you live?
    ❒ alone
    ❒ unclear family
    ❒ with family mixing with many other families
    ❒ with big/extended family
    ❒ with friends of both genders ______________________ persons altogether
    ❒ with friends of the same gender ______________________ persons altogether

Socialising/Recreation

29. How often do you participate in social events in this community place (e.g. go the temple, make merit, attend a religious ceremony?)
    ❒ frequently ❒ occasionally ❒ never because ______________
30. What recreational activities you participate in with your compatriots here? (multiple responses possible, please rank by giving high no. to frequent activities)
    ___ sports ___ watch TV ___ socialising & chatting
    ___ drinking ___ watch VDO at VDO shop ___ go to tea shop
    ___ go to entertainment places (Karaoke, bar, brothel)
    ___ others specify ______________________

Contact with family/relatives in place of origin

31. Whom do you contact in hometown?
    ❒ no contact because ______________________
    ❒ contact (person) ______________ times/year in average.

32. Do you send money or valuable things to someone in hometown?
    - ❒ no, because ______________________________
    - ❒ yes, send money to ______________________________
    - ❒ yes, send valuable things to ______________________________
33. What means do you use to send money/thing? (multiple response possible)
    - ❒ carry it by yourself ❒ ask relatives/acquaintance to carry for you
    - ❒ relatives come to pick it here ❒ through bank or post office
    - ❒ use informal remittance service
34. How much do you send per year? ____________ Baht
35. What will you choose between bringing your family to stay with you here and returning home to visit them frequently?
    - ❒ family stay here ❒ return to visit family

36. How often do you go to visit your friends and relatives?
    - ❒ never return (skip to 43)
    - ❒ occasionally
    - ❒ regularly __________ times/year in average

(Item 40-41 for those who return only)

37. When was the last time you visit home? ______________ months/years ago
38. What did you do when you visited home?
    - ❒ meet relatives/friends ❒ socialising, drinking
    - ❒ others specify ______________________________

Income and saving

39. Did you earn income in Myanmar/Cambodia?
    - ❒ yes ❒ no (skip to 44)
40. How much did you earn per month? ____________ baht
41. What occupations are the major sources of your income in Thailand? (Please rank from most important source to moderate ones)
    - ___ agriculture ___ fishery ___ related to fishery
    - ___ construction ___ water transportation ___ production
    - ___ services (hotel, food shop, domestic work) ___ labourer, vendor
    - ___ CSW ___ no income
    - ___ others specify ______________________________
42. What kind of payment you have here?
    - ❒ daily ❒ weekly ❒ bi-weekly ❒ monthly ❒ yearly ❒ by job
    - ❒ other ______________________________

43. Your average income is ____________________ Baht per month
44. Have you had any saving in the last year?
    - ❒ no because ______________________________ (skip to 50)
    - ❒ yes ______________ Baht approximately
45. What did you do with your saving?
    - ❒ send to family ❒ pay debt ❒ keep for personal use
    - ❒ other specify ____________________

Skills and Knowledge acquired

46. What skills do you want? (Multiple responses possible)
    ❒ Thai language ❒ English language ❒ manual skills for work
    ❒ other ______________________ ❒ no skill wanted
47. What skills have you acquired?
    ❒ no skills acquired
    ❒ yes, skill ______________________ from ______________________

Plan for future

48. Do you plan to stay in Thailand or return to Myanmar/Cambodia?
    ❒ return ❒ stay in Thailand ❒ go to third country
    ❒ other ______________________
49. For those who plan to return, when will you return?
    Within ______________ months/years
50. You will return to state/division/town ______________________
    with ______________ because ______________________
51. How long do you plan to stay in Thailand ____________ months/years
52. If you can choose between staying in your country and working in Thailand, what will you choose?
    ❒ work in Thailand ❒ stay in country

PART THREE: HEALTH SEEK BEHAVIOUR

53. Do you know that there are health care services (health station, hospital, etc.) here (in Thailand)?
    ❒ yes ❒ no
54. Have you or your family members been ill and received health care from health care services in Thailand?
    ❒ yes
    ❒ no. I have never used such services because
        ❒ I have never been ill
        ❒ I don't think I have the right to use the services
        ❒ The cost of care are too high ❒ other specify
    Then skip to 60
55. For those who have used health care services in Thailand, what are the major problems you encountered? (Multiple responses possible)
    ❒ high cost ❒ language communication problem ❒ bad treatment
    ❒ being rejected for service ❒ no problem ❒ other specify ______________
    For single respondents, skip 60 and 61
56. While you live here, have you got any children?
    ❒ no (skip to 62) ❒ yes

57. If yes, where were the babies delivered?

Place of delivery	No. of babies delivered in Thailand	No. of babies delivered in Myanmar

58. While you are living in Thailand, have members of your family age below 1 year been vaccinated?
   - ❒ yes for ________ times ❒ no (skip to 64)
   - ❒ not sure/don't know (skip to 64) ❒ no children age below 1 year (skip to 64)

59. If yes, what vaccine?
   - ❒ don't know ❒ vaccine for ____________________

60. Do you or your family member have the following illness?
   If yes, where do you receive treatment?
   - ❒ no, not ill
   - ❒ yes, specify illness and treatment

treatment / Illness	State hospital		Health Station		Private hospital		Private clinic		Traditional healer		self cure		other specify	
	Thai	yan / amb	Thai	yan / amb	Thai	yan / amb	Thai	yan / amb	Thai	yan / amb	Thai	yan / amb	Thai	yan / amb
1 T.B (infection stage)														
2 Filariasia (infection stage)														
3 Amphetamin/ Heroin addict														
4 Leprosy (infection stage)														
5 Syphilis (3rd stage)														
6 Mental disorder/ Down syndrome														
7 AIDS (full blown)														

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

61. While you are living in Thailand, where will you/your family member go for treatment if you are very sick.

place of treatment	in Thailand	in Myanmar/Cambodia
State hospital Health station Private hospital Private clinic Traditional healer self cure Doctor without license(?) Other specify		

PART FOUR: KNOWLEDGE, ATTITUDE AND RISK BEHAVIOUR ON AIDS

Channels of knowledge about AIDS

62. Had you ever heard about AIDS when you were in Myanmar/Cambodia?
- ❒ no
- ❒ yes, from what sources? (multiple responses possible)
  - ❒ inter personal source ❒ TV/radio ❒ newspaper/periodicals
  - ❒ poster/sticker ❒ Burmese/Cambodian health officers
  - ❒ teacher/school ❒ NGOs ❒ other specify __________

63. Have you heard about AIDS while you are in Thailand?
  - ❒ inter personal source ❒ TV/radio ❒ newspaper/periodicals
  - ❒ poster/sticker ❒ Thai health officers ❒ no information
  - ❒ teacher/school ❒ NGOs ❒ other specify __________

64. Have you ever head about Sexually Transmitted Diseases (STD)?
  - ❒ no
  - ❒ yes, (check respondent to name some examples of STD)

General Knowledge about AIDS

What do you know about AIDS syndromes and AIDS test

		Correct/ Yes	Not correct/ No	Don't know/ not sure
65	AIDS can be cured.	❒	❒	❒
66	Do HIV+ persons have to have symptoms	❒	❒	❒
	What symptoms do PWHA have			
67.	Weight loss	❒	❒	❒
68.	White coating in the tongue.	❒	❒	❒
69.	Chronic diarrhoea.	❒	❒	❒
70.	Chronic cough.	❒	❒	❒
71.	Chronic fever.	❒	❒	❒
72.	Skin have red bottons.	❒	❒	❒
	How can HIV be detected?			
73.	Urine test	❒	❒	❒
74.	Blood test	❒	❒	❒

Knowledge on transmission

Can the following behaviours transmit AIDS ?

	Behaviours involving HIV + person	Yes	No	Don't know/ not sure
75.	Touching	❐	❐	❐
76	Sharing glasses and dishes	❐	❐	❐
77	Sharing toilet	❐	❐	❐
78	Sharing clothes	❐	❐	❐
79	bitten by mosquito carrying HIV+ blood	❐	❐	❐
80	blood transfusion	❐	❐	❐
81	Intact skin touching with HIV+ blood	❐	❐	❐
82	Sharing razor/needle	❐	❐	❐
83	share syringe	❐	❐	❐
84	homosexual intercourse	❐	❐	❐
85	heterosexual intercourse	❐	❐	❐
86	Anal sexual intercourse	❐	❐	❐
87	oral sex	❐	❐	❐
88	Deep kiss, exchange of saliva	❐	❐	❐

Knowledge on prevention

		Yes	No	Don't know/ not sure
89.	Using condom every time you have sex	❐	❐	❐
90	Selecting healthy, clean person to have sex	❐	❐	❐
91	Having sex with women who are not sex workers so that condom is not required	❐	❐	❐
92	Do you believe in practising withdrawal before orgasm	❐	❐	❐
93	Do you believe in drinking alcohol before or after having sex to prevent AIDS	❐	❐	❐
94	Do you believe that regular blood test every 3 months can prevent AIDS	❐	❐	❐

Attitudes towards AIDS patients and risk behaviours

		Yes	No	Don't know/ not sure
95	AIDS is a severe communicable disease, however transmission is not easy and we should not treat patients badly	❐	❐	❐
96	Can feel pity for PWHA	❐	❐	❐
97	Can work and live with PWHA	❐	❐	❐
98	If your friend get AIDS, you will visit him/ her	❐	❐	❐

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

99	PWHA should stay separately from other people and receive special care	❒	❒	❒
100	Do you have relatives, friends or acquaintances who have AIDS?	❒	❒	❒

101.If a member of your family or your close friend gets AIDS, what will you suggest to them?

❒ go to the hospital ❒ self medication

❒ go to temple name ________________ ❒ other specify ____________________

Attitudes towards risk behaviours

		Agree	Disagree	Don't know/ not sure
102	It is OK for married men to have sex with sex workers	❒	❒	❒
103	It is OK for single men to have sex with sex workers	❒	❒	❒
104	It is OK for single men to have sex with any women who are not CSW	❒	❒	❒
105	It is OK for married men to have sex with any women who are not CSW	❒	❒	❒
106	It is OK for married women to have sex with other men who are not their husband	❒	❒	❒
107	It is OK for single women to have sex with men	❒	❒	❒
108	Men need sexual initiation (kheun khru) as normal process (with CSW)	❒	❒	❒
109	A man must have sex without condom to express his courage as a man	❒	❒	❒
110	Drinking before and after having sex can prevent AIDS	❒	❒	❒
111	Using condoms will reduce sexual pleasure	❒	❒	❒
112	Drinking before and after having sex will make men more virile	❒	❒	❒
113	Using condom suggests that they are unfaithful/untrustworthy	❒	❒	❒
114	Marble implant or penis injection will please partner	❒	❒	❒
115	Drugs can help when we have stress or problems	❒	❒	❒

116. What do you think of drug users?

❒ look down on them ❒ accept them ❒ it's a personal matter

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Self evaluation for AIDS risk

117. How will you evaluate your risk to be infected?
- ❒ no risk at all because ______________________
- ❒ little chances because ______________________
- ❒ probably at risk because ______________________
- ❒ high risk because ______________________
- ❒ not sure, don't know ______________________

118. Why do you think you need to prevent yourself from AIDS infection? (please rank reason)
- ___ because it is so near to us
- ___ because it is shameful to be infected
- ___ because I am afraid of being dead
- ___ because my family will be infected too
- ___ other specify ______________________

Risk behaviour (within one year)

119. Do you drink (alcohol)?
- ❒ never ❒ yes If yes ❒ only in the past, not now
- ❒ rarely ❒ regularly, how frequent?

120. Do you smoke cigarette?
- ❒ never ❒ yes If yes ❒ only in the past, not now
- ❒ rarely
- ❒ regularly, how frequent?

121. Do you smoke marijuana?
- ❒ never ❒ yes If yes ❒ only in the past, not now
- ❒ rarely
- ❒ regularly, how frequent?

122. Do you take amphetamines?
- ❒ never ❒ yes If yes ❒ only in the past, not now
- ❒ rarely
- ❒ regularly, how frequent?

123. Do you use condom with partners other than your spouse?
- ❒ every time ❒ sometime ❒ never ❒ no sex with others

124. Have you injected drugs?
- ❒ yes ❒ no

125. Have you shared needles with others?
- ❒ yes ❒ no

126. Have you had a blood transfusion?
- ❒ yes ❒ no

127. If yes where?
- ❒ Hospital ❒ Thai ❒ Myanmar/Cambodia
- ❒ Health station ❒ Thai ❒ Myanmar/Cambodia
- ❒ Private hospital ❒ Thai ❒ Myanmar/Cambodia
- ❒ Private clinic ❒ Thai ❒ Myanmar/Cambodia
- ❒ other specify ______________________

Attitudes towards Thai people

How do you think about various groups of Thai people?

	Good	Moderate	not good	no contact
128. Thai people in general				
129. Employer				
130. military, police, immigration				
131. health officer				

Risk behaviours related to sex and condom use

132. Have you ever had sexual relations?

133. What was your age the first time you had sex?

134. Do you know what a condom is?

135. Have you ever seen a condom?

136. Where have you seen condoms?

137. During this year, have you had sex?
❐ yes ❐ no, skip to 139

138. If yes, with whom, and how frequently condoms were used?

	no.	condom use		
	of partners	every time	some time	never
(1) Spouse				
(2) Lover				
(3) Acquaintance				
(4) Married woman				
(5) Direct CSW				
(6) Indirect CSW				
(7) Other specify				

137. Who do you usually use condoms with?

138. **(Ask men only)** Have you ever had sexual relations with sex workers?

139. **(Ask men only)** If so, how many times with sex workers in the past 12 months?

140. Who did you have sex with last?

141. When did you have sex last?

142. **(Ask men only)** The last time you had sex with a sex worker did you use a condom?

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

143. What are condoms useful for (why do you use)?

144. Do condoms affect your feelings and sensations during sex.

Other risk behaviours

145. In the last 12 months, did you have an STD?
❒ yes ❒ no, skip to 141
146. If yes, where did you go for treatment?

Place	in Thailand	in Myanmar/Cambodia
State hospital		
Health station		
Private hospital		
Private clinic		
Traditional healer		
Self cure		
Non-licensed doctor		
Other specify		

147. During this year, have you received injections for health treatment? (by yourself, friend or non-licensed doctor)
❒ yes ❒ no
148. (**Ask men only**) During this year, have you had penis injection?
❒ yes ❒ no
149. (**Ask men only**) Have you had marble implant?
❒ yes ❒ no, skip to 145
150. If yes, when was that?
❒ within a year ❒ more than a year
151. After knowing about AIDS, will you change your risk behaviour?
❒ yes ❒ no

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย