Cross-border Migration and HIV/AIDS Vulnerability at the Thai-Cambodia Border Aranyaprathet and Khlong Yai

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March 2000

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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.

Dr Surapone Virulrak
Acting Director, Institute of Asian Studies

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This situational analysis of cross-border migration and HIV vulnerability on the Thai-Cambodian borders is a collaboration between the Asian Research Center for Migration (ARCM) of the Institute of Asian Studies at Chulalongkorn University and the AIDS Division, Department of Communicable Diseases, Ministry of Public Health, and is supported by the World Health Organization (WHO), Thailand.

Many people in the border areas of Aranyaprathet and Khlong Yai contributed to this study, in addition to those from Bangkok. We would like to express our 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. Dr Wiput was the Director of the AIDS Division when this study was undertaken, and he and his colleagues deserve many thanks for their insightful comments and suggestions on the design and the methodological approaches. Our thanks also go to Dr. B. Doberstyn, WHO Representative for Thailand, and Khun Laksami Suebsaeng of WHO, for their continuous support to the project. Dr. Nonglak and Dr. Suchada Bowarnkitiwong from the Department of Educational Research, Faculty of Education at Chulalongkorn University kindly gave advice on sampling design and statistical analysis of data. Ms Therese Caouette provided sound comments on an earlier draft of the report.

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Within ARCM, Dr Supang has been the strategist and co-ordinator of the study. Ms Amorntip Amaraphibal was the main field investigator and the main contributor in the statistical analysis of data. Praweenya Suwannatthachot coordinated data research in Trat and undertook statistical analysis of data and preparation of graphs. Allan Beesey was responsible for interpretion of data and analysis, plus writing of the report. We would like to thank all ARCM staff who have assisted in this project, including Ms Tharin Clauwat for the preparation of maps, Mr Suthee Bunla for the cover design, Dr Nonglak Wiratchai for advising on statistics and Dr Andreas Lamerz who assisted in editing.

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Cambodian health volunteers from Koh kong

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARCM	Asian Research Center for Migration
CARE	Charitable American Relief Everywhere
CBO	Community Based Organization
CSW	Commercial Sex Work(ers)
FHI	Family Health International
GTZ	Deutsche Gusellschaft fuer Technische Zusammenarbeit
HIV	Human Immuno-deficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPD	In-patient Department
MCH	Maternal and Child Health
MOPH	Ministry of Public Health (Thailand)
MSF	Medicins Sans Frontieres
NCA	Norwegian Church AID
NGOs	Non-governmental Organizations
OPD	Out-patient Department
PLA	Participatory Learning and Activities
PWHA	People Living With and Affected by HIV and AIDS
SEAMEO	Southeast Asian Ministers of Education Organization
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
WHO	World Health Organization

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CROSS-BORDER MIGRATION AND HIV/AIDS VULNERABILITY AT THE THAI-CAMBODIA BORDER: ARANYAPRATHET AND TRAT

EXECUTIVE SUMMARY

This study is part of a series of studies ARCM is undertaking at eight border locations in Thailand. The eight sites border Myanmar, Cambodia and Malaysia, and research is undertaken through funding from WHO Thailand, UNAIDS Thailand and Ministry of University of Affairs Thailand. The study sites in this report are Khlong Yai (Trat) and Aranyaprathet (Sakaew), and in the accompanying report the sites are Sangkhlaburi (Kanchanaburi) and Ranong. Two other studies have been completed - Mae Sot (Tak) and Mae Sai (Chiang Rai), and two more are being prepared – Sadao (Songkhla) and Sungai Kolok (Narathiwas).

This study utilised structured interviews as the core instrument of research. In addition, qualitative research using key informant interviews, in-depth interviews and group discussions was used to collect background information and to support the interpretation and analysis of quantitative data. Secondary data was collected from health and other government institutions as well as other research and program reports.

The study is undertaken primarily on the Thai side in all sites; however, in Aranyaprathet it was necessary to also explore the situation in Poipet where most of the migrants lived and where sex workers reside and work. Cross-border collaboration is seen as crucial to the long term prospects of HIV/AIDS programming; however, for practical purposes it is perceived as necessary to concentrate efforts on one side of the border while exploring and monitoring the potential and development of cross-border networks.

A major finding of this study is that if the border sites are seen as junctions where the border crossings join as much as separate the two countries then risk situations on one side of the border will effect those on the other side. The two sites in this study present very different contexts but both sites present a similar picture of risk: high prevalence of HIV, higher prevalence of STDs than in Thailand, and extensive commercial sex.

In the context of porous borders migrant workers easily pass from one country to the other. Incomes at half the rate that Thais might earn are sufficient to tempt them across the border where Thai employers seek them out. Many have travelled from provinces well inside Cambodia and their expectations are to earn money for their families that accompany them, or back at home. They are usually undocumented migrants with little or no Thai language, little or no financial safety net, and limited access to health services.

They enter into this vulnerable existence with one objective – to earn money. They seem ill-prepared to deal with the changes they must face in this culturally familiar but different social and economic climate. Many were farmers in Cambodia, now they are labourers, working in construction or on the land, loading boats or trucks, fishermen, processing fish, maids or sex workers. The living circumstances may not

be hygienic, they may be crowded slums, or single basic rooms with little space or amenities, or fishermen on their boat. They face health risks, and many insecurities with being on daily contracts, or due to factory closures, or the impact of the recent economic downturn, or being harassed by police.

In this context they have to keep their family together and healthy, and have some sort of recreation. There is no-one looking after their welfare, their only safety net is perhaps going back to the village. Young men or married men away from home have to look after themselves, and they too are in need of recreation. Border areas are well known for providing 'entertainment zones', and these two border areas are no different, thus, for many, there are few recreational alternatives apart from drinking and commercial sex

It is in this context we return to the HIV/AIDS situation, and how ill-prepared migrant workers are for this situation. Many have little education and thus low literacy, and they have limited knowledge and many misconceptions regarding the transmission and spread of HIV. They know little about STDs and the importance of condom use. Yet, as part of their recreation, they join many other groups, who are also mobile populations – truck drivers, traders, business people, tourists, officials, soldiers, police – in visiting sex workers.

Overall the situation of condom use is probably lower than any other place in Thailand, except for other border areas such as on the Myanmar border. There is a range of reasons that condom use is low or inconsistent and these are discussed in the report. The nature of border areas is that they offer opportunities and a degree of freedom often not experienced at home. Such opportunities include illicit activities, such as gambling and commercial sex work. Gambling has been a feature of these border areas and as with many other border areas this has been legitimised through the establishment of casinos within a short walk of the Thai border. In Trat the demand for sex work has arisen with fishermen and the nature of their work taking them out to sea for periods of time, and wanting outlets for 'relaxing' when they return. In Aranyaprathet, a large military presence followed by economic development with an influx of traders, truckers, tourists etc. has created the demand. Thai sex workers and sex work establishments have given way to Cambodian and Vietnamese sex workers.

Aranyaprathet has a relatively high number of never married men but most are living with families. Many families have migrated as a group or have followed the first member who migrated. Thus, most do not have contact with their hometown, and many do not remit money, among those who remit money the amount is usually minimal. Most of the migrant workers live in Poipet and commute daily for work, apart from some farm areas further inside the district and in adjoining districts. The risk factor for most migrants is on the Poipet side, for their family life, and more importantly their social life, is in Poipet. They mainly seek health services in Poipet as well, with limited numbers visiting the hospital or health stations.

Aranyaprathet is a busy market area, attracting many traders and business people. As the major thoroughfare from Thailand to Cambodia many trucks pass through or stop at the border area. There are many sex workers in bars and brothels in Poipet who service Thais on business, tourists, or officials, in addition to many Cambodians. They are also transported across the border daily to service mainly Thai clients. This area

has been the site for trafficking of women and is reported to be well known for smuggling drugs and other goods. Risk factors for HIV infection also exist on the farm areas where sexual networking, including Cambodian women selling themselves, and violence toward women reportedly occurs. Condom use is generally low or inconsistent and the knowledge of HIV/AIDS is limited with many misconceptions.

In Trat there are many single men, including married and never married. They often live in single accommodation such as fishermen living on their boats. Many appear to be supporting families back home so they are more likely to remit money home than respondents in Aranyaprathet, and they send substantially higher sums of money. Fishing is the main industry providing the mainstay of the economy, even more so since the closure of most sawmills. Some industries employ mainly women and pay lower wages that the men.

The port area is comprised of village communities of mostly Cambodian migrants. There are 'red light' zones here that cater mainly for fishermen but many other men as well. Thus, migrant workers are within Thai precincts and many utilise health services within Khlong Yai. Fishermen, of course, are very mobile, and so are sex workers. Both can be found in sites just across the border in Cambodia. They are also found on local islands. Unlike many other migrants they are unlikely to seek health care at the Khlong Yai hospital, either going to private clinics or self-treating in Koh Kong, or for fishermen, out at sea. Vulnerability to HIV infection occurs through limited understanding of HIV transmission and spread, but also through multiple partner sex, primarily commercial sex, in a context of inconsistent use of condoms. Higher incomes, such as that of some fishermen, and other groups, allows for greater opportunities and enhanced risk.

Summary of key findings **Khlong Yai – Koh Kong**

Migration behaviour and conditions in the border region

1. A major fishing port is the economic mainstay of Khlong Yai, where established villages of Cambodian migrants, and mixed Khmer and Thai communities exist.

2. There is only one cross-border checkpoint, the immigration check-point situated at the southern tip of Khlong Yai District. However, many people cross into Cambodia, both legally and illegally, by boat.

3. Occupations, such as saw mills and fishing, employ single men without families and provide accommodation. Most are never married men, but both married and single men are living away from their home. The other major employer of men is labourers who load and unload the boats.

4. Many migrant women are employed, and they are predominant in fishery processing as well as service industries, including sex work, and are also commonly working as traders. Women receive less pay, and on average have a lower education than men.

5. Respondents are from many areas but most come from Kampot, Kampong Cham, Koh Kong, and Phnom Penh. Approximately a third of the sample worked as farmers before migrating

6. Only 16% return home frequently, just over 20% visit home once or twice a year, the remainder have never returned home. Amost half the sample remits money home and the majority send remittances to their parents, often substantial sums of money. Thus, many single and married respondents appear to be supporting families back home.

7. Illegal status is a problem for many, it has been particularly so for those in sawmills who have had to be very careful moving outside of the work and living compounds, and enforcement of undocumented migrants is becoming more common.

8. Almost 20% have only been in the area for six months or less and a similar proportion over four years, with the remainder in-between. Those who had been in the area longer were more likely to have proficiency in spoken Thai and in comprehension.

HIV/AIDS: awareness - attitudes - misconceptions

9. Awareness and understanding of HIV/AIDS is inadequate with many misconceptions on prevention as well as on some practices and beliefs that are potentially high risk behaviours.

10. Fear of PWHA even though most people identified casual contact as not being a means of transmitting HIV.

11. Low income and low education is associated with inadequate understanding of HIV/AIDS transmission as well as misconceptions on prevention and transmission, and this is pertinent for women, including sex workers.

Risk situations

12. High prevalence of HIV/AIDS on the border, particularly across the border in Koh Kong where STDs appear to be a major concern as well.

13. High risk situations with large commercial sex industries exist on both sides of the border, and in addition there are similar but smaller ports on islands in the area which are high risk areas.

14. Large populations of fishermen who spend their earnings on drinking and sex work when in port. Such risk behaviours are encouraged through life style and habits of crew and captains. Many are married, or never married men, living away from home.

15. Risk behaviours occur among high income groups as well as those who have a relatively good knowledge and awareness of HIV/AIDS, again the main group in this category is fishermen earning relatively high wages.

16. Higher income earners and those with prestige or authority, who should also have knowledge of HIV/AIDS, have easy access to sex workers and most of these are Thai, such as tourists, business men, uniformed men and other officials.

17. Condom use in commercial sex work is inconsistent and is particularly low among regular partners. Only a third of the sample knew that condoms can be used as contraceptives as well as protection against STDs; and almost half of all women report never having heard of condoms.

Health services and attendance

18. The illegal status of migrants, language and finance, are factors that inhibit migrants from seeking treatment; however, Cambodian migrants do seek treatment from the community hospital in Khlong Yai and from all health stations. Over 50% of respondents have been to the hospital.

19. Married, and older respondents are much more likely to seek treatment at the hospital than young, single respondents. Fishermen and sex workers are the least likely to go to the hospital, however, fishermen attend health stations.

20. NCA has supported STD/HIV programming through the hospital, 1993-1998. Some cross-border collaboration continues from this programme but with limited resources. CARE Thailand is now working in Khlong Yai.

Aranyaprathet - Poipet

Migration behaviour and conditions on the border

1. The majority of workers in Aranyaprathet are daily commuters, up to 4,000 may cross per day. Up to 1,000 are seasonal workers on farms who live in relatively isolated areas for the duration of the work period.

2. In the main check point, a large market area, the main occupations are traders, retailers, service industry workers, porters and labourers. Elsewhere people are working on farms or labouring work.

3. The majority of respondents come from Bantery Meanchey, 40%. Most others come from Battambang, Siem Reap, and Kampong Cham – half of the respondents were farmers before leaving for the Thailand.

4. The majority of workers live in families and many work as couples or in family groups. They have migrated together or followed the first member of the family who migrated. Agents were not generally used by migrants to find work.

5. There is a relatively large population of never married men but most are living with families. Thus, few people are supporting families at home (the picture may be different for sex workers and other migrant workers in Poipet).

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6. Over half the sample have no, or little, contact with their hometown, thus, 65% never send money, and over half of those who do send money send less than B1,000 annually. Small remittances corresponds with low incomes, 80% earn below B2,000.

7. About 40% of the sample visit home regularly (at least once or twice per year).

8. Almost 30% have been in the area over two years and more than half of these over four years, but at the same time over 35% have been in the border area three months or less.

HIV risk situation

9. The border crossing is a major centre of business and trade, attracting not only migrants but many others, including truckers, tourists and business people.

10. Trafficking of women was common in the past, and for some years there has been a big demand for sex workers from the different mobile population groups as well as the large military presence. Other uniformed men are regular customers of Poipet sex workers.

11. Migrants from elsewhere in Cambodia are also employed in the relatively large precincts of Poipet. The construction of a large casino complex has employed many migrants.

12. Commercial sex has reduced in Aranyaprathet with most of it being indirect sex work with Thai women. No Cambodian or Vietnamese sex workers were found to based in Aranyaprathet township.

13. The high risk situation for migrants is in Poipet, where there is a high prevalence of HIV, STDs, and extensive commercial sex. The same sex workers often service migrants as well as Thais and foreigners; the latter are serviced either directly in brothels on the Poipet side or through being transported to hotels and guest houses in Aranyaprathet.

14. There is evidence of extensive sexual networking outside of commercial sex, and violence to women, especially on the farms where there are many seasonal workers.

15. Condom use is highly inconsistent in commercial sex work, and both single and married male migrants are known to engage in sex outside of their regular partner. The most inconsistent use is among Cambodian sex workers, rather than Vietnamese, and among Cambodian men rather than Thai men.

HIV/AIDS: awareness - attitudes - misconceptions

16. Awareness and understanding of HIV/AIDS is inadequate with many misconceptions on prevention as well as on some practices and beliefs that are potentially high risk behaviours.

17. Misconceptions on transmission of HIV, namely that HIV can be transmitted through casual contact, corresponds with a high degree of fear toward PWHA.

18. Women have low education, low income, and low HIV/AIDS knowledge.

19. Low income and low education is associated with inadequate understanding of HIV/AIDS transmission and spread; and low education is associated with certain beliefs and attitudes that potentially lead to high risk behaviours; however, such attitudes can be found across all income and educational levels.

Health and HIV/AIDS services

20. Most migrant workers seek health care services on the Cambodian side of the border. Government services are very limited and pharmacies and private clinics often have unqualified people in attendance, otherwise cost is a barrier to adequate services. Attendance in Aranyaprathet is normally for minor complaints where workers attend health stations, or for emergencies they might attend the hospital.

21. MSF is currently providing a clinical service for STDs and reportedly has many people seeking treatment. They also undertake outreach work on HIV/AIDS.

Recommendations

Aranyaprathet – Poipet and Khlong Yai – Koh Kong

There has been minimal HIV/AIDS programming on either side of the border. Thus recommendations are based on possible interventions that can guide government or NGOs in the design and implementation of interventions. It is highly recommended that NGOs undertake work in the area in co-operation with the local health departments and other agencies. The wider the network of agencies the more possibility for effective interventions that can encompass the communities of migrant workers while at the same time including other mobile populations as well as local populations.

The Thai health department has been active with some programming but this needs to be upgraded substantially if there is to be any impact on the target populations. On the Poipet side there seems to have been little if any prevention work, except for the efforts of MSF over the past few years. Medical facilities need to be upgraded and better resourced in Poipet if the government health department is to support or initiate HIV/AIDS programming. In any case, prevention and care programs need to be carefully designed and implemented with support and input from a range of stakeholders. Initially, stakeholders and other participating agencies need to be identified and recommendations 1 & 2 work towards this end. The following recommendations are modified from more comprehensive and site-specific recommendations in sections 3.12 & 4.12.

1. **Formation of a local working committee** – to take responsibility for determining needs and resources, and coordinating the implementation of prevention and control activities. Ideally this committee has wide representation that includes bodies that are involved in the employment as well as the welfare of migrants, and migrant representatives themselves.

2. **Organising local workshops** - as an initial stage for the formation of the proposed local committee. The main focus would be to disseminate and discuss the findings and recommendations of this study with all stakeholders. This can be followed by discussion on possible funding, the structure and function of the local committee, the outline of a proposed work plan.

3. **Employers** - businesses and industries that employ migrant workers should be encouraged to participate in exploring strategies to improve health care for migrant workers. The benefits of having a healthier workforce should be explained to gain their cooperation.

4. **Cross-border collaboration**

Exchanges between any health sectors on both sides of the border can assist in providing information materials, distribution of condoms, and other prevention and care activities. The means to effective collaboration may evolve over time as programming develops on one or both sides of the border, arising out of identifying areas of need that can benefit from exchanges of information and regular communication and cooperation.

5. **Targeted programming** should aim to reach particular groups: those known to have high risk behaviours; those who are vulnerable due to lack of knowledge and awareness; those who have little power or authority; or those who are difficult to reach. Findings from this study suggest that some of the following targets and activities should be considered in interventions.

- Gaining cooperation from Thais employers to gain access to workers for providing information, training, and identifying peer educators.

- Mobile teams of educators could disseminate information and HIV/AIDS leaflets and materials, as well as condoms, especially for the more isolated areas.

- Women should be targeted through special leaflets, posters and other media materials. Targeting family groups may assist in reaching women, who generally have low HIV/AIDS knowledge, and married men who often have low knowledge as well.

- Identifying hotels and other venues that are appropriate targets for the dissemination of HIV/AIDS information and condoms.

- Establishing savings groups, especially for fishermen, and ways of making payments to fishermen in order to avoid squandering or losing money.

- Establishing a range of activities that can support individuals and provide an alternative to drinking and commercial sex. Revolving funds, sporting activities, home drinking parties, regular video nights (with informative programming as well entertainment).

- Exploring ways to reaching undocumented workers, and also newcomers who should be exposed to information on HIV/AIDS as soon as possible.

- As an adjunct to the above the feasibility of establishing networks that can provide pre-departure information on conditions on the border and HIV/AIDS knowledge could be explored.

- IEC materials on STD/HIV/AIDS, and other health problems, should be available in Khmer language to be disseminated on both sides of the border.

6. **Community mobilisation** is necessary for effective programming which in turn is dependent upon community participation. The first steps in community mobilisation are Steps 1 & 2 above, but no time must be wasted in bringing these plans and proposals down to the community level and testing ideas in the field through practical sessions with the migrants themselves.

- In Khlong Yai there are settled villages along the border, and also in Poipet. Thus there are communities that can be identified. Occupational groups, such as fishermen or farm workers, especially if they are both living or working together can be identified as a community where peer and participatory approaches can be explored.

- The potential for peer education strategies can be explored among sex workers, labourers, fishermen, villagers, women, etc. Such strategies can be enhanced through participatory approaches such as inventive training programs, PRA activities, and life-skills programmes.

- Peer education can be used for most groups and is not just for those perceived to be at high risk. If the focus however, is clearly on the community this approach can help to avoid stigmatisation of certain groups.

- Integrated programming, which adding or integrating HIV/AIDS programs into literacy and/or health programs for women, or income generation for women which includes HIV/AIDS programs. Such programmes could be designed for PWHA groups as well.

- All pharmacies and private clinics should be a part of the mobilisation of the community. Their cooperation is essential for control and management of STDs, for helping to improve understanding, even if they just help in disseminating educational materials on prevention and care.

General Recommendations

Understanding the local conditions and the situation of HIV/AIDS, plus the attitudes and perspectives of local agencies and other stakeholders, is crucial in forming appropriate and workable recommendations. Site specific recommendations are made at the end of each chapters 3 and 4 (see sections 3.12 and 4.12) and summarised above. The following are a summary of the recommendations presented in full in Chapter 5. In addition to their relevance to the study sites they may have a wider application. These proposed recommendations may have direct relevance for other cross-border locations, and in turn the development of national level strategies for planning and co-ordination of intervention activities.

1. **Improving legal status:** Illegal status of migrant workers is a major obstacle to the development of health services for the large majority of migrants in Thailand. Clear policies should be developed for on migrant.

2. **Creation of an 'enabling environment':** Provincial level authorities plus local immigration officials, border police and military must participate with the health department, NGOs, private sector and other civil society institutions to create an enabling environment in support of the migrants.

3. **Developing monitoring and evaluation tools for border programmes:** The findings of this study, as well as other studies, are refining our understanding of cross-border locations. However, further investigation is needed to develop indicators for assessing progress in interventions in the unique situation of mobile groups and cross-border locations.

4. **Mass media programmes for border population**: Many local and migrant people in border areas do not have a clear knowledge of the disease and health risks they are facing. Well coordinated mass media campaigns can disseminate information on both sides of the border in appropriate languages.

5 **Advocacy for migrant workers:** With the formation of local and national committees as recommended in the site specific recommendations (3.12 and 4.12) a sub-committee can be formed to raise awareness on migrant workers, supporting their rights as workers in Thailand and highlighting special issues of concern.

6 **Public health services:** The possibility of raising local funds through health cards or a social security scheme for registered workers could be explored. This could assist in the provision of services that are not currently available for migrant workers.

7 **Training for uniformed officials**: Immigration officials, police and military can be included as mobile groups, living away from home. Findings suggest that many are highly vulnerable to HIV infection. Training could provide an informed and comprehensive picture on the situation of HIV/AIDS on the border and the necessity of all mobile groups being informed on safer sex practices.

Chapter 1

CROSS-BORDER MIGRATION AND HIV/AIDS VULNERABILITY AT THE THAI-CAMBODIA BORDER ARANYAPRATHET AND TRAT

Over the last two decades rapid economic growth in Thailand has effectively transformed the country from a labor exporter during the 1970/80s to a *de facto* labor 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 the economic crisis and increased 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 desintation, others transit through border areas on their journey to and from their destination sites further inside Thailand.

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 artifacts.

Border locations have become of critical concern in recent years in the fight against AIDS. In 1997 with the support of WHO and SEAMEO/GTZ, ARCM organized the Second Technical Consultation on Trans-national Population Movement and HIV/AIDS in Southeast Asia. In the past couple of years mobile populations and border-crossings have appeared on the agenda of most international agencies 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 for HIV infection 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 2400km; but even the border that divides Cambodia and Thailand stretches to 798km. The estimations of HIV infection in Cambodia now give it a great per capita rate of infection than Thailand. 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 situations. In addition, the study explores health seeking behavior 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 and surrounding countries.

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 15% decline in new infections (UN World AIDS Report 1998). 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 1.5% of pregnant women are HIV positive compared to the peak of 2.3% in 1995; and 21% of the direct sex workers are positive in 1997 compared to a high of 33.2% in 1994. The trend is almost similar to other sentinel groups with the exception of IDUs who have a consistently high infection rate, in 1998 it was 47.5%. During this period, almost all national HIV/AIDS programs have targeted the Thai population. Very few programs 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 neighbouring countries

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. This is a serious situation indeed considering the first reported HIV case at the country in 1991. In a WHO/Ministry of Health report in 1997 show 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 HIV infection in pregnant women at the eastern area was eight times more than those in the western region of the country. National sentinel surveillance data of 1998 shows that 1.8% of pregnant women were pregnant, 29.8% of sex workers, and 61.9% of IDUs were HIV positive.

The estimated number of people living with HIV/AIDS in Cambodia was 180,000 adults in 1998, 3.7% of those aged 15-49 years old; a higher rate than that of Thailand, and the highest rate of any Asian country (HIV & AIDS Case Reports: trends in the Western Pacific region, WHO). This very rapid increase occurred in the last seven years since the first reported case in 1991. HIV/AIDS prevalence has been remarkably high in the northwestern region of the country bordering Thailand, but HIV has been reported for every province and all population groups. National Sentinel Surveillance in 1998 shows that pregnant women have rates up to 6%, sex workers up to 64%, and police up to 25%. In Koh Kong province, bordering Trat province of Thailand, pregnant women had rates of 19.5% in 1997, policemen had rates of 21% and the military of 10% (UNAIDS/WHO).

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, from Myanmar especially, 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 in 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 attempts in 1992 and 1994 to regulate the flow of undocumented migrant labor flow into the country. During this last round, the

migrants from three neighboring 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 many provinces of the country. The migrants in eight occupations were authorized to register i.e. construction, fisheries, fisheries related industries (pier work, fish categorization, 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 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 laborers 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% (Ministry of Labour and Social Welfare 1997). 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, approximately 200,000 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 Laborers by Gender in Thailand

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

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

Migrant workers and other 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 & Sovannath 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 risk situations for HIV/AIDS among migrant populations. The emphasis is on exploring correlations on migration processes, behaviour, and living/working conditions with vulnerability for HIV/AIDS.

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

2. To study behavior 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 behaviors 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

1 The **location of research** is undertaken in immediate border areas where some workers may be daily commuters or longer term workers, and further inside the district or province where mainly seasonal workers are employed in agriculture or in factories, as well as other occupations like fishing.

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.

Presentation

This study presents background, methodology, and findings from primary and secondary sources, plus analysis and recommendations for future programming of the two Cambodian 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 that covers all relevant issues for this study. This is followed by a literature review of relevant documents for the Thai-Cambodian border.

Chapter 3 presents the situation and findings of the Aranyaprathet-Poipet study, and Chapter 4 the Trat-Koh Kong 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. There is a summary after each section, followed by a summary of findings and discussion. Finally there site-specific recommendations which bring together different agencies and stakeholders to plan and implement appropriate interventions.

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. General recommendations are made that complement the site-specific ones.

Selection of study sites

Four locations along the Thai-Myanmar and Thai-Cambodia borders were selected on the basis of the high volume of cross-border traffic. The two Thai-Myanmar locations appear in an accompanying report.

1. Aranyaprathet district of Sakeo Province opposite Poipet in Srisophon Province
2. Khlong Yai district of Trat province opposite Koh Kong Province
3. Sangkhlaburi district of Kanchanaburi Province opposite Ban Phaya Tong Sue of Myanmar
4. Amphur Muang of Ranong Province opposite Kauthaung of Myanmar

[Two other Myanmar border locations, Mae Sot of Tak Province and Mae Sai of Chiangrai Province have been studied - funded by the Ministry of University Affairs, Thailand. Two more case studies will be conducted on the Thai-Malaysia border.

Methodology

The core of the research was a survey with structured interviews. 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.

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.

MAP 2

MAP OF THAILAND AND ITS NEIGHBOURING COUNTRIES SHOWING PRINCIPLE THAI BORDER CROSSING POINTS AND STUDY SITES

Source: Shakti Paul, Asian Research Center for Migration, Institute of Asian Studies, Chulalongkorn University, 1998

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. Survey of the study population by using structured structured interviews. 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. There is further discussion on the questionnaire and implementation of the survey in Methodological Issues in Chapters 3 and 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 correlations are interpreted and discussed.
For each level of analysis the significant P value is $\leq .05$

Relevant migrant behaviour variables were not identical in both sites and the different variables and the different findings are discussed in the second report, on Trat, 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 variance) 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 also tested through linear regression analysis.

Chapter 2

Conceptual framework on International Migration and HIV/AIDS

This discussion on the conceptual framework covers the topics of international migration and its linkages to health and HIV/AIDS.

1. International migration : definition, types and causes of migration

International 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 one year as the length of stay in the new destination 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 followed (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 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,

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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 neoclassical 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 labour shortages. (Frequently, workers migrate illegally to work in the secondary sector.) 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 - departure, migration and arrival. The variables in the five aspects and three stages of the system are summarised in the following table.

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Table 2.1 A Summary of 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 covenent
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 from review of documents 1995.

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.

List of migration variables

Departure stage

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

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

2. 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 right to be treated when they are ill. With regard to AIDS, HIV screening of migrants is a violation of human rights. Migrant's 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/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 services, 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

The following conceptual model represents most of the variables which have been reviewed. It also indicates the relationship among variables.

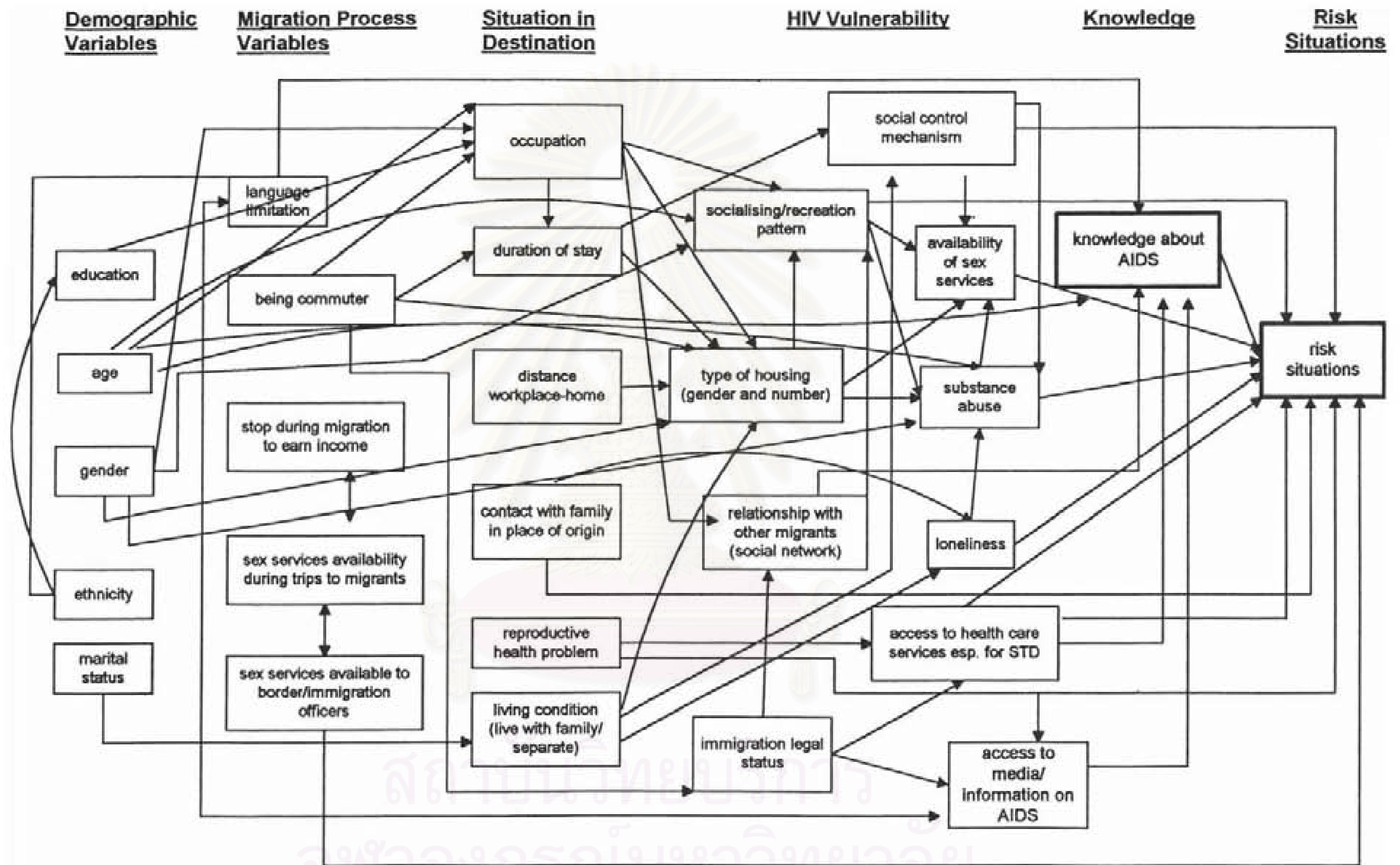


Figure 2.1. Conceptual Model of Factors Affecting HIV/AIDS Knowledge and Risk Situations of Cross-border Migrant Populations

Supang Chantavanich, August 1999

Description of Conceptual Model

Variables in the conceptual model can be classified into six categories, that is, demographic variables, migration variables, situation in destination country variables, HIV vulnerability variables, knowledge and attitudes on HIV variables and the final category is the risk situations/behaviours which are to be explained by the previous categories of variables. 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 and substance abuse, while gender is related to socialising patterns and substance use or abuse 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.

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 the migrant's 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 STD, and directly to risk situations also. 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 status, availability of sex services, substance abuse, loneliness, access to media/information on HIV/AIDS. Social control mechanism is related to availability of sex services and substance abuse 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 abuse. 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/information on AIDS.

Loneliness is an important variable, which can influence drug 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/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, relationships 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 use, loneliness and level of knowledge and attitudes on HIV/AIDS.

Literature Review: Cambodia, and Cambodia-Thai border

There is limited data on the border areas regarding concerns and conditions of migrants working in Thailand, especially that of the Cambodian border. Much of the literature on migrants in Thailand focuses on migrants from Myanmar and much of this material is more general and not necessarily focussed on conditions on the border areas but on border issues and legal and employment issues regarding migrant workers. However, HIV/AIDS research on border areas in recent years, particularly the Myanmar border but also on the Cambodian border, does highlight the living and working conditions of migrant workers and the particular problems they face.

There is much literature on Cambodian refugees and the relocation of migrants from the various refugee camps near the Cambodian border, but little of this is relevant to current conditions, which has only emerged in the last eight or nine years as a result of economic expansion and increased opportunities on the border. Refugees who were unable to settle are among those who have returned to the border area to seek work. With UNAIDS and other agencies turning their focus to border areas and migrant and mobile populations in recent years there is an increasing body of literature reporting on migrant and mobile populations and exploring what might be unique characteristics of these population groups, particularly in the context of cross-border locations. Recent reports on the Cambodian-Thai border are reviewed below.

One recent paper was useful in providing information on migrant workers and the reduction in migration due to the economic crisis in Thailand, although this reduction was much more apparent among workers travelling beyond the border to Bangkok and other regional areas, mainly to work in construction. The authors, Chan Sophal and So

Sovannath (1999), conclude that job prospects have fallen sharply and this is adversely affecting the local economies in Cambodia, especially in border provinces, that have become dependent on the incomes from migrant workers. Despite the reduction in work opportunities they added that many people "still believe that migrating to Thailand is a risk worth taking". This indicates how strong the 'push' factors are, for example, widespread landlessness was cited as a major factor in influencing migration for work.

Another report, Public Health Burden at the Borders (Somsak Pattarakulwanich et al 1999), looks at health care in border areas in Thailand. From secondary data it forms a profile of migrants 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.

A report from Mahidol (Pramualratana et al, 1995) is a comprehensive qualitative study of the same two sites studied here, also focusing on the HIV situation but more on the actual context than a sharp focus on migrants, although fishermen are discussed in some depth, as well as their wives and other community members. The research for this report was conducted over five years ago and while some of the information is dated it provides useful insights and a basis for looking at changes over the past five years.

Several papers from the proceedings of the Second Technical Consultation on Trans-national Population Movement and HIV/AIDS in Southeast Asia were useful for background material and in analysis of the findings. This consultation was organised by ARCM in 1996 and the report published in 1997. Three papers in particular provided useful material. Kien Serey Phal provided an overview of internal and cross-border migration in Cambodia with a focus on Cambodian women and girls migrating to enter the sex trade, either voluntarily or through being trafficked. Chou Meng Tarr provided a long report on commercial sex work in Phnom Penh focussing on the attitudes of young men and especially pertaining to their attitudes and behaviour with regard to Vietnames sex workers working in Phnom Penh. The country report on Cambodia (Hor Bun Leng) 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.

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 CARE Thailand (1999) focuses on migrants and HIV/AIDS in Khlong Yai, Trat. It is a rapid site assessment that hones in on migrant's sexual behaviour, HIV/AIDS knowledge, and associated issues of STDs and condom use. STDs are looked at in the context of health seeking behaviour, and the commercial sex scene is described with discussions on the main actors, namely sex workers, fishermen, and sawmill workers. The report notes that the while sawmill workers may frequent sex workers less than fishermen both groups include many single men.

This is strictly qualitative research conducted in two short periods of time in December 1998 and again in February 1999. The data and recommendations in this report are currently being utilised in a project with an office and local staff in the fishing port area of Had Lek, Khlong Yai District. The study is part of a broader initiative in cross-border HIV/AIDS work in Southeast Asia known as BAHAP (Border Area HIV/AIDS Prevention Project). This report does not examine the situation in Koh Kong, however, research has been conducted in Koh Kong in a similar time frame and complements this research.

The Koh Kong research was undertaken by a research team in Cambodia but this too is part of a bigger initiative looking at fishermen and fishing ports in the region and is a collaborative project of international agencies such as UNICEF (1999), other UN and international agencies, and NGOs, including CARE Thailand. This is a qualitative rapid assessment similar to the above report on Khlong Yai but with a distinct focus on fishermen, or other seafaring workers such as those working on cargo or passenger vessels. Interestingly, one of the findings in this draft report was that it should not be necessary to have a major focus on fishermen or seafarers as they are only one of the mobile groups in Koh Kong that are at risk through commercial sex and sexual networking. At the same time this group of migrant workers were found to be at high risk – largely due their being away from home for long periods, having relatively high disposable incomes, and having spent a lot of time in men-only groups. These form some of the core findings in our report as well.

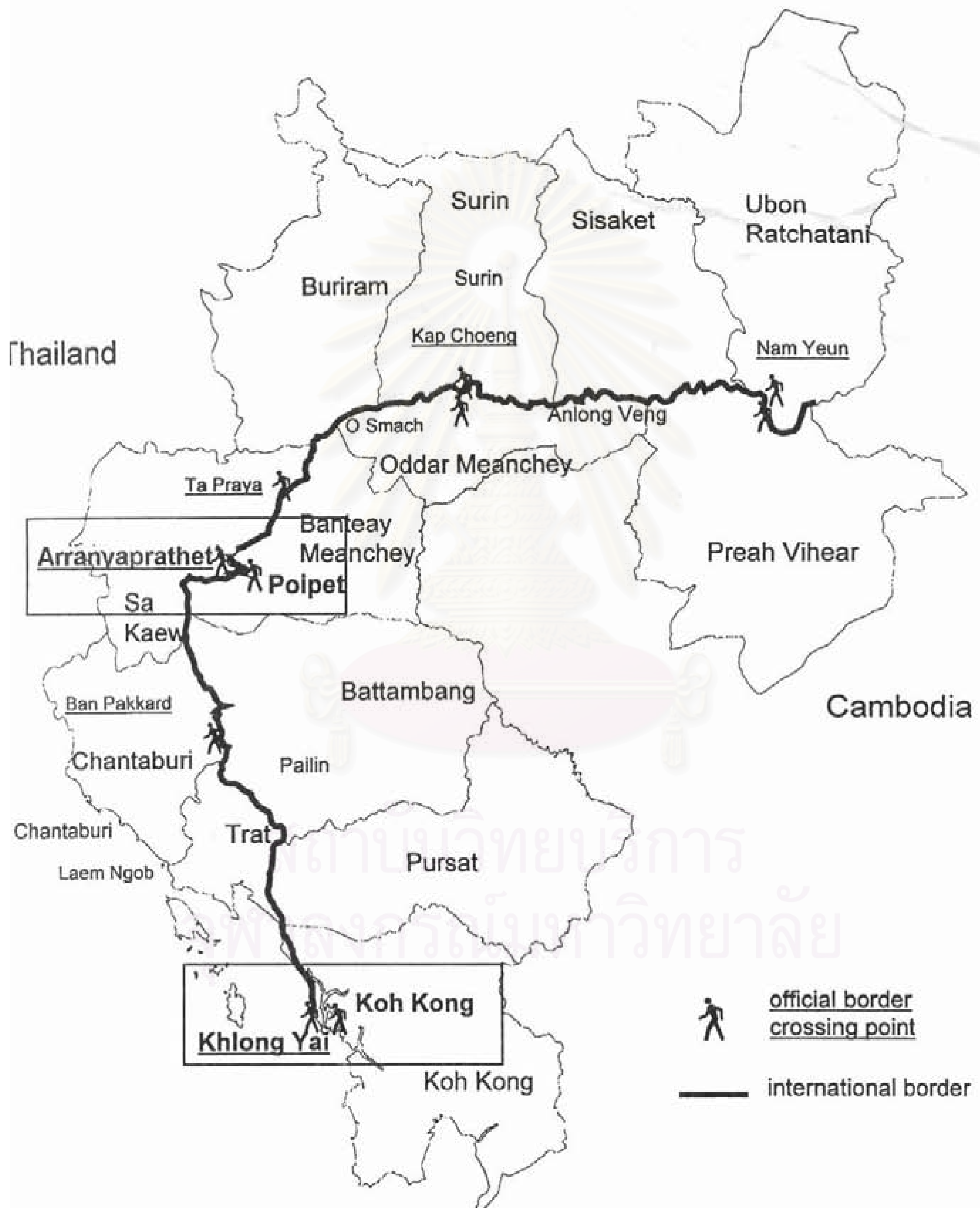
Almost all of the fishermen, and the sex workers, who were interviewed knew of someone who had AIDS, which indicates the severity of the spread of HIV in Koh Kong. In this context condom use was described as erratic, with condoms often not being used when drunk, suggesting that safe sex was not always a priority even with the knowledge of an HIV epidemic.

CARE Cambodia conducted a rapid assessment of Poipet in January 1998, which as with the CARE Thailand report in Trat focuses on the risk situation with an exploration of commercial sex, STDs and condom use (see Press 1999). The report identifies at risk groups among all mobile populations groups.

The collaborative project mentioned above with UNICEF and international agencies that coordinated research in Koh Kong has also undertaken work in Vietnam, Thailand and Myanmar. It has produced an extensive report on the situation in Ranong with a focus on private sector involvement in prevention and care programmes. Another study of note is that undertaken by Achara Thawatwiboonpol Entz backed by a collaborative team of researchers. This was a biomedical study determining prevalence of HIV infection among Thai, Burmese and Cambodian fishermen and the subtypes of HIV present in that population. Socio-demographic and behavioural data was collected and correlations determined between that data and those who tested positive. Of 818 men tested 15.5% were found to be positive.

MAP 3

Thailand - Cambodia border area



สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Part I **CHAPTER 3**

CROSS-BORDER MIGRATION BEHAVIOUR AND HIV/AIDS

The Border Area: Introduction and Background

3.1 Introduction

Aranyaprathet is the border town of Sakaew province, a newly formed province 236 km west of Bangkok, established in 1993 as the 74th province in Thailand. The population of the province is 547,385 (December, 1997). Most of the terrain is mountainous but with adequate lowlands to cultivate substantial cropping, such as, corn, sugar cane, rice and cassava. Logging was very common until bans were implemented a few years ago. Much labour is required on the many lowland farming areas near the border. The province of Sakaew shares a 165 km border with Cambodia and the district of Aranyaprathet takes up 80 km of this. The central and northern sections of the district lie in a valley but toward the south of the district the border area is mountainous. The mostly wooded mountains of Thailand form a strong contrast with the denuded mountains of Cambodia.

Aranyaprathet is the third most populous district with 81,624 people. Aranyaprathet township is six kilometres from the border, but Poipet on the Cambodian side is much closer to the border. Poipet is in the district of Srisopon in the province of Banteay Meanjey. Military conflicts in the area have reduced in recent years allowing the border to be opened more consistently than four or five years ago.

Border crossings and population groups

This is a busy border crossing with a large transitional population conducting business or seeking work or other opportunities. The majority of crossings are people looking for work, but also includes traders and other business people and officials. The canal which divides the two countries does not provide a formidable barrier despite a military guard. The majority of border crossings are by Cambodians, many of whom are locals and have relatives, friends or other contacts across the border. Many local people are bilingual and religious and cultural traditions are shared across the border.

There are market areas on both sides of the border with goods from neighbouring countries, such as China. Many traders in the area rely on men carrying their goods from one side to the other. These men with long rectangular carts make numerous trips loaded with goods, and some carry people across. Human labour is beginning to be displaced however, with the introduction of motorised carts carrying heavy goods that formerly might have been pulled by ten to thirty people. Many trucks line up on both sides to unload or cart goods across the border.

Amidst the tourists and the casino patrons, the traders and the cart-pullers, the workers and officials of various sorts, truck drivers, people selling produce and others begging for

work, food or money, are a large number of young children. As workers and especially as foragers and beggars they have existed in the market area for several years.
The majority of crossings are from Cambodia but there is a consistent stream of people crossing from the Thai side, one estimate is 200 - 300 per day. Many are traders or tourists, including men who visit sex workers in Poipet, but includes local officials, residents and others. There is only one official immigration check point, situated in the Klong Leuk Village area at Rong Kluer market. This was established as an official check point under the Ministry of the Interior, in April 1998, replacing the existing check point which was administerd by provincial authorities. There are 2,000 - 3,000 border crossings per day where most crossings are daily commuters from Cambodia who are issued with border passes that require them to return by 4PM the same day. These numbers are a significant increase from estimates of 400 official crossings five years ago, with more on weekends (Pramualratana, 1995), and are reflected in documented annual figures over the past five years (Table 3.2).

Young children and sex workers crossing from Cambodia, usually through the main check-point, are technically illegal; however, children are often ignored and so may sex workers be, although agents may pay for their passage. Many people cross at various points despite surveillance by the military. It is easy to cross the canal as it is dry most of the year, and even within sight of the main check point people pass illegally. It is not surprising then that some Cambodians stay in Thailand overnight or longer. While this is not common in Aranyaprathet, at least in the township and local environs, it does occur within farming areas to the north of the district where 500 to 1000 Cambodians are employed seasonally in groups of 40 to 100 persons (Table 3.1). The head of such groups is known to, and trusted by, the employer and takes responsibility for recruitment. While the average age of these workers is lower than the age of workers who commute daily there are also many married couples, often with children. In such cases they carry essential food items to last for the duration of work which may be one to three months. To the southwest of the district and in the adjoining district of Ta Praya there are many more workers. A district to the north is another destination and one official suggested that there may be as many as 20,000 migrant workers in these three districts at any one time.

Along the border there are designated check points, to the north and south of Khlong Luek, where daily commuters cross to seek employment on farms and in construction. There are 500 to 2,000 such crossings daily (Table 3.1). The numbers of crossings fluctuate as well as the numbers actually employed each day. The check-points are controlled by border officials, or by soldiers who guard the entire length of the border, and authorize border crossings at designated areas. Employers arrive in the early morning to select men and women for a days work, returning them by 5PM. There is no issuance of border passes, employers simply sign for how many workers they take.

At the close of the data collection period a check point was opened at Nong Plue in the southern section of the district. According to informants this new check-point was established to deal with the increasing numbers crossing the border and would only be providing daily border passes, primarily for traders and workers.

Table 3.1 Estimates of Migrants Crossing the Border

Study sites	Area 1	Area 2	Area 3
Location	Immigration check-point Khlong Leuk	Several check-points for workers	Farming area in north – (excludes southwest area)
Type of migrants	Daily commuters	Daily employment	Seasonal workers staying in Thailand
Estimates of workers	2,000 to 3,000 per day	500 – 2,000 per day	500 – 1,000 per season

In Area 1 estimates of numbers of workers in each occupational group are as follows: traders 1,000; store employees 400; and labourers/porters 1,600. In Area 2 the upper estimate is 200 labourers and an estimated 1,800 people working in the rice fields. Area 3 has approximately 200 people working in rice fields and 800 in sugar cane fields. The total is approximately 6,000 workers although there may be other seasonal workers near the borders of adjoining districts (see Map 4 - next page).

Table 3.2 shows the official border crossings, there was little rise in the numbers between 1996 and 1997 reflecting the economic slowdown in Thailand at this time. The large increase in 1998 is unaccounted for but perhaps it reflects increases in contruction work and general production in the area, as well as elsewhere in Thailand.

Table 3.2 Official Border Crossings, Khlong Leuk

	Thai	Khmer
1994	13,897	273,121
1995	71,964	285,759
1996	118,515	546,387
1997	132,196	598,530
1998	119,729	941,643

Trade and work opportunities

The focus of this chapter is to explore the lives of Cambodian migrant workers and correlate some of those experiences with factors that might put them at risk of HIV infection. The harsh history of the people of Cambodia has been a factor in the Khmer being industrious people and seeking greater opportunities. At least 85% of the people are farmers, and as in Northeast Thailand, they rely on rain fed crops, which usually allows for only one crop per year. Thus rural people are used to seasonal movements looking for work, either close to home or in other districts or provinces. In the border region of Poipet many people have travelled from adjoining provinces, or more distant provinces, seeking the opportunities that economic activity on the border provides. Substantial numbers of these are some of the tens of thousands of recently resettled refugees, and others may be refugees who were resettled in areas near the border region (Sophal & Sovannarith 1999).

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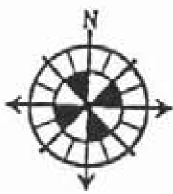
MAP 4: BORDER SITE

Aranyaprathet District



To Sakaew

Bangkok

D. Khoksung

SD. Nong Chan

SD. Parai

Khlong Luek

Poipet

D. Aranyaprathet

SD. Takham

SD. Khlong Namsai

V. Pansuek

V. Nong Prue

SD. Ta Prik

Cambodia

D. Khlonghad

Health Station Utilised by Migrants

Border

Sub district

Village

Area 1

Area 2

Area 3

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Most of the work in Aranyaprathet is agriculturally based work, although construction and other forms of labour have attracted many migrants as well. Trade and construction work, however, have decreased due to the economic crisis in Thailand. A new market was built beside the old market, Talat Rong Kluer, however, construction stalled for some time and many shop buildings have remained empty since construction was completed in December 1997. There was much construction in the township of Aranyaprathet up until two years ago when it appeared to come to a standstill due to the economic crisis; however, local informants suggest that it has been picking up since the beginning of this year. Trade actually increased after the crisis as exports became very competitive due to the devaluation of the baht; however, with the stabilisation of the baht trade and business generally has been in decline.

Some construction has occurred in Poipet, most noticably the recently constructed new casino, complete with duty free facilities, and a hotel complex is planned. Apart from the casino and a few other facilities, Poipet is economically deprived with very basic infrastructure and health and welfare services. There is no hospital and a proliferation of private clinics and pharmacies where many establishments do not have qualified staff.

The appeal of Poipet to migrants as far away as Vietnam is its border environs with Thailand, where opportunities for work and trade act as a magnet for migrants. Despite difficult travel conditions with poor roads and mountainous areas people travel backwards and forwards across the country. While some workers are long time residents and have no wish to return home others visit home regularly. Family members may travel to receive wages from their spouse or children working in the area, this is pertinent to sex workers who make up a substantial proportion of the Poipet population. In addition, men and women may travel to Phnom Penh or the Vietnamese border to purchase women for sex work, and sex workers may travel backwards and forwards, individually, with agents, or with family members.

Some of these women are very young and thus they form part of the children at risk in the area. As stated above there are many young children in the general vicinity of the border, with many of them foraging for scraps of metal or other materials to sell or use.

Mobility as a Precursor to Risk

As discussed, a large proportion of the population is transitional, migrating to the area to take advantage of greater opportunities. From sex workers to police and military, plus seasonal and other workers, there is often a set pattern of movement. Sex workers may return home to take money and they may leave the trade, however, the greater movement is the regular turnover, which may occur every few months, and is organised by brothel agents and owners to ensure new girls are available. As stated above, agents may also travel regularly to recruit women.

Thai border police and regular police belong to a small region of provinces and every few weeks may be moved from one to the other. Soldiers belong to a larger regional grouping but this still involves regular exchanges of personnel. The heads of police and soldiers are

involved in this movement but they are placed in one position for a period which can be up to four years but is often much shorter. Similar movements are likely to occur with Cambodian personnel in the armed forces and within the police.

Truck drivers travel to the area frequently and some Thai trucks can cross into Cambodia. On the Poipet side it is estimated that there are up to1000 truck drivers, working for five transport companies, that transport Thai and Cambodian goods across the country (CARE Cambodia 1998). It is further estimated that another 200-500 drivers transport people and lighter goods around the province and outside the province (CARE Cambodia). Records from the Transport Ministry in Bangkok show that from November 1997 to May 1998 an average number of 193 cars, trucks and other vehicles, such as buses, crossed the border. In June 1998 there were 815 vehicular crossings, and in July 1,480. There is no explanation for these large increases of June and July. In August and September there were fewer crossings but greater numbers than previously, 256 and 315, respectively.

Traders may travel to major regional centres to purchase goods and thus follow circular routes. Those who do well have money to spend on entertainment en route and at their destinations, perhaps like truck drivers, and officials, including police, whose meagre incomes can be inflated through extra earnings for favours and support. Tourists complete the picture of those with disposable incomes who can afford entertainment and sex. Many have come from major centres and experience a comfortable life with regular drinking and entertainment, which usually means access to many women.

Thus, the area is a special zone, a meeting point for a transitional population that are far from home and often far from their families. There is a certain lawlessness that could be enhanced by a new casino and more tourists, as some people have predicted for the casino in Koh Kong (BKK Post 28/2/99). Health and social welfare appear to be second to earning money for those trying to exploit every opportunity to make their riches. While for many migrants the struggle for economic survival directly puts their health and social welfare at risk. This is the case on the Poipet side in particular, but it can extend to the border region and beyond. Many visitors, including researchers, avoid staying in Poipet, not just because of the better facilities on the Thai side but because of the crime and lawlessness on the Cambodian side.

Commercial sex

The sex industry based in Aranyaprathet has drastically reduced, leaving few Northern Thai women in employment. This is partly to do with internal changes in the industry in Thailand but partly, it appears, through the relatively low prices being asked for Vietnamese and Khmer women, who do not live on the Thai side but frequent it nightly through arrangement with agents and their customers in the many hotels and guest houses of Aranyaprathet. The economy is largely dependent on Thai people spending through investments, trade, consuming goods and services, and this includes the sexual services of young Vietnamese and Cambodian women.

With many workers commuting and with a limited sex work industry on the Thai side the primary risk environment for many migrants is Poipet. Recent estimates suggest the number of sex workers at several hundred, which is down from an estimated 1,000 five years ago, in "95 registered brothels in the entire district and 50 unregistered" (1 p20). Current estimates from the local authority are 35 to 50 brothels with 400-700 sex workers. An NGO estimate was 34 registered brothels and 400-450 direct and indirect workers. Another estimate from January 1998 was 25-30 brothels and 150-200 sex workers (CARE Cambodia, 1998). This latter estimate was after fighting in the area and a major fire in Aranyaprathet, apparently these factors tended to reduce the numbers of Thais seeking-out sex workers in the area. However, the numbers may have reduced to some degree due to the economic crisis, which through affecting tourism and business, as well as work and trade opportunities, has had an impact on the numbers of Thais and Cambodians coming to the border. Construction work has resumed in Aranyaprathet just this year, after coming to a complete standstill since 1997. This appears to be an indication of a return to more prosperity, and thus it may well be that the numbers of sex workers are increasing to meet the rising demand. Apparently, a relatively new development is more indirect workers, such as freelance girls who rent small houses and visit entertainment areas independently, and others include advertising or promotion girls.

Sex workers in Poipet move across the border at night, often they are bicycled across to the many guest houses and small hotels, or major hotels in Aranyaprathet. They serve Thai officials and tourists and foreign tourists, but also officials or businessmen from Cambodia. They return to Poipet the following morning. In addition, Thais cross into Poipet to visit the Khmer and Vietnamese sex workers during the day. Most Thais may be able to afford the more expensive Vietnamese workers who are reportedly noted for their cleanliness and beauty compared to the Khmer workers (Pramualratana, 1995; CARE Cambodia, 1998). The women sent across the border are generally from brothels in Poipet but it is possible to get women from local villages as well.

3.2 Public Health Services: Aranyaprathet and Poipet

Aranyaprathet is a district with modern and accessible medical services. In all there are 14 health stations in the district with a large district hospital that has 120 beds. There is also a military hospital that has 90 beds, but mainly serves only military personnel. The existence of two large hospitals reflects the needs of a border plagued by war and dislocations. In addition to these services there is five community health centres, one municipal sub-district health service, and one malaria centre. There are eight private clinics in addition to many pharmacies, a herbal pharmacy and a Red Cross centre.

The hospital in Aranyaprathet, unlike many other border areas, has not treated many migrants. From 1993 to 1997 it treated an average of 125 patients per year, but over half of these were refugees. The situation has changed since 1998 when the hospital treated 405 migrants, and in addition, 85 refugees. However, it seems that many of these migrants may have been wealthier people from across the border, and if indeed this is the case this would not put so much strain on hospital finances. In 1998 the hospital also experienced its biggest ever loss of income, B668,830. This may be due to some patients not being able to pay the full costs, but it is also due to the hospital only receiving minimal support from NGOs. In the past the hospital was subsidised by one and half million baht over four years, according to hospital documents, to provide treatment for refugees. Earlier this year the last of the refugee camps on the border closed.

Some migrants utilise Thai health stations, especially those close to the border, of which there are six centres. Documentation from the district public health office shows that over the six month period of October 1998 to March 1999 250 migrants sought treatment at these six health stations.

In contrast the Thais side, Poipet has far fewer facilities. Poipet is not a district or district town, it is a border town in the district of Serei Sophon, although the area may be upgraded to a district. There are two government clinics in Poipet with observation beds. Neither have doctors in residence and few people attend with the one of the main services being to provide vaccinations. They are not always opened it seems, however, if someone attends with a fever or serious problem they can be put under observation and referred elsewhere. Hardly anyone attends with ordinary diseases and for serious problems many will go to Serei Sophon district hospital, 20 kilometres from Poipet. This is a relatively large district hospital with 30 beds. Then there is Mongkhon Buarai Hospital, which is the provincial hospital approximately 50 km from Poipet with over 200 beds. However, this trip may take three or four hours over rough roads.

There are many pharmacies in Poipet and there are many private clinics, which often provide birthing services. However, some of the people providing the services are not fully qualified but local Khmer people apparently cannot discern who is, or is not, qualified and thus refer to them as doctors.

One of the qualified doctors from a private clinic suggested their prices are higher than clinics where untrained people treat patients. The private clinics have better quality service and medicines but people often choose the cheaper clinics. The result, he claimed, is that misdiagnosis and incorrect methods of treatment often lead to the patient's symptoms getting worse.

There are eight doctors who have graduated form medical school, and most have opened private clinics. The doctor mentioned above was one of three who in partnership had opened a large clinic. This clinic has three floors with 15 beds and includes facilities for birthing and for staying overnight.

3.3 STD/HIV/AIDS Situation 1994 - 1998

Sexually Transmitted Diseases

In Thailand, with increasing awareness, improved diagnosis and treatment, and a relatively high use of condoms in commercial sex, the incidence of HIV has reduced significantly over several years. In Cambodia the incidence of STDs has increased over this same period of time. In Aranyaprathet the incidence of STDs is documented as being higher than other districts but overall in Sakaew Province the incidence is not much higher than the national average, although the most dramatic declines were only in 1997. Table 3.3 shows the results of tests conducted on people attending the STD clinic in Sakaew.

Table 3.3 Number of People Tested and Results at the Sakaew Province STD Clinic

Attending STD clinic	1994		1995		1996		1997	
	tests/+	%	tests/+	%	Tests/+	%	tests/+	%
Men	359/103	28.6	365/91	24.9	426/80	18.7	434/35	8.1
Women	954/26	2.7	1242/21	1.7	1931/22	1.1	1255/5	0.4
Sex worker	1040/206	19.8	565/33	5.8	442/17	3.8	234/2	0.8

Report on AIDS and STDs from Sakaew Public Health Department, 1997

The most common STDs were syphilis and NGCs. Equivalent statistics for Aranyaprathet district from 1994-1997 are in the following table.

Table 3.4 Number of People Tested and Results at the Aranyaprathet Hospital

Attending STD clinic	1994		1995		1996		1997	
	tests/+	%	tests/+	%	Tests/+	%	tests/+	%
Total	902/269	29.8	424/95	22.4	469/79	16.8	239/25	10.46

Report on AIDS and STDs from Sakaew Public Health Department, 1997

During the year of 1998 in Aranyaprathet 19 sex workers were tested for STDs, these women undertook 207 tests with seven positive cases over the year (3.38%). Two of the

positive women were under 18 years old. Apart from sex workers 38 people attended the STD clinic for diagnosis and 13% were found to be positive, and 95.6% of these were reported to have used condoms in all commercial sex visits. Most people seeking treatment for STDs would attend private clinics and many self-treat by purchasing antibiotics from pharmacies. As noted in the Mahidol report, packaged medicines, *ya chut*, have long been available for treating STDs, although it is not clear that these are still purchased for STDs.

In Poipet, Medicine Sans Frontier have an STD centre where they provide testing and counselling for STDs as well as counselling and information on HIV, but no testing as yet for HIV. At present testing is only conducted in Srisophon, but MSF hope to be able to begin testing soon. MSF have many patients, but limited documentation, one person estimated 35 patients a day. Among the patients are both men and women, most of the women are sex workers, and labourers, police, soldiers and housewives are treated as well (see CARE 1999). Many people it seems come as a last resort when medication or other service providers have not helped them. The reason often being is that they have resistant strains of gonorrhea. That there are resistant strains, or that symptoms do not respond to treatment, reflects the situation in Cambodia where it appears that the latest antibiotic treatments are not being used by most medical practitioners. Other STDs include chancroid and syphilis. Each Wednesday and Friday MSF conduct outreach with education and counselling to brothels in Poipet.

HIV/AIDS

The HIV/AIDS situation is outlined in Chapter 1 and is presented here again, firstly with tables comparing prevalence data of Sakaew, Trat, along with national data; and then some comparative data from Banteay Meanchey and Koh Kong in Cambodia. Further elaboration is made on the situation in Sakaew Province and Aranyaprathet District with some discussion on Poipet. For further discussion on Trat and Koh Kong see this section in Chapter 4.

From the tables it can be seen that pregnant women in Sakaew have higher rates than the Thai national average for the first time in 1998, and sex workers have had consistently higher rates since 1995.

There are an estimated 8,000 people with HIV in Sakaew with 738 documented as having contracted HIV and having developed AIDS or having AIDS related symptoms. Over 75% are reported to have been infected through heterosexual sex contacts. Over 50% are casual labourers or workers and 35% are between 25 and 29 years of age.

Up until 1997 almost a quarter of all AIDS cases were from Aranyaprathet. The only other district with higher proportion was the Muang District, the municipality of Sakaew, with just over a quarter.

Table 3.5 National HIV Sentinel Surveillance Results, Thailand with Selected Study Sites on the Thai-Cambodia Border

Mean HIV Positive Among Pregnant Women, 1991-98

Location	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
Trat	1.00	0.76	2.22	5.00	1.72	4.38	2.79	2.17	4.23	5.50	5.50	3.33
Sakaew*	1.00	1.55	1.23	3.97	2.11	2.63	2.75	1.38	2.35	1.49	1.49	2.57

Mean HIV positive among Direct Sex Workers, 1991-98

Location	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
Trat	28.57	31.20	40.27	39.47	26.32	43.62	36.00	N/A	3.00	34.00	53.85	47.93
Sakaew*	17.00	11.68	27.00	27.00	33.06	35.44	26.67	24.39	24.18	39.47	31.82	0.00

Date source : Division of Epidemiology, Ministry of Public Health, Thailand .*Mixed Direct and Indirect sex workers N/A = Date not available

HIV Sentinel Surveillance Results in Selected Thai-Cambodia Border Province

Percent HIV positive, 1996-98

Sentinel groups >>	Pregnant Women		Married*	Direct CSWs			Police			Military		
Location	1996	1997	1998	1996	1997	1998	1996	1997	1998	1996	1997	1998
Cambodia	1.73	3.20	2.4	40.88	39.31	42.6	5.46	6.00	6.2	5.95	7.10	N/A
Koh Kong	5.26	19.50	6.0	52.10	52.00	41.0	14.29	21.00	25.80	11.76	10.00	N/A
Banteay Meanchey	1.69	3.81	0.2	54.49	58.08	54.0	11.76	8.73	10.00	6.52	N/A	N/A

Data source : AIDS Division, Ministry of health, Cambodia. * Data on pregnant women N/A

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Figure 3.1 HIV/AIDS Sentinel Survey on Pregnant Women in Thailand and Selected Thai-Cambodia Border Provinces, 1990-1998

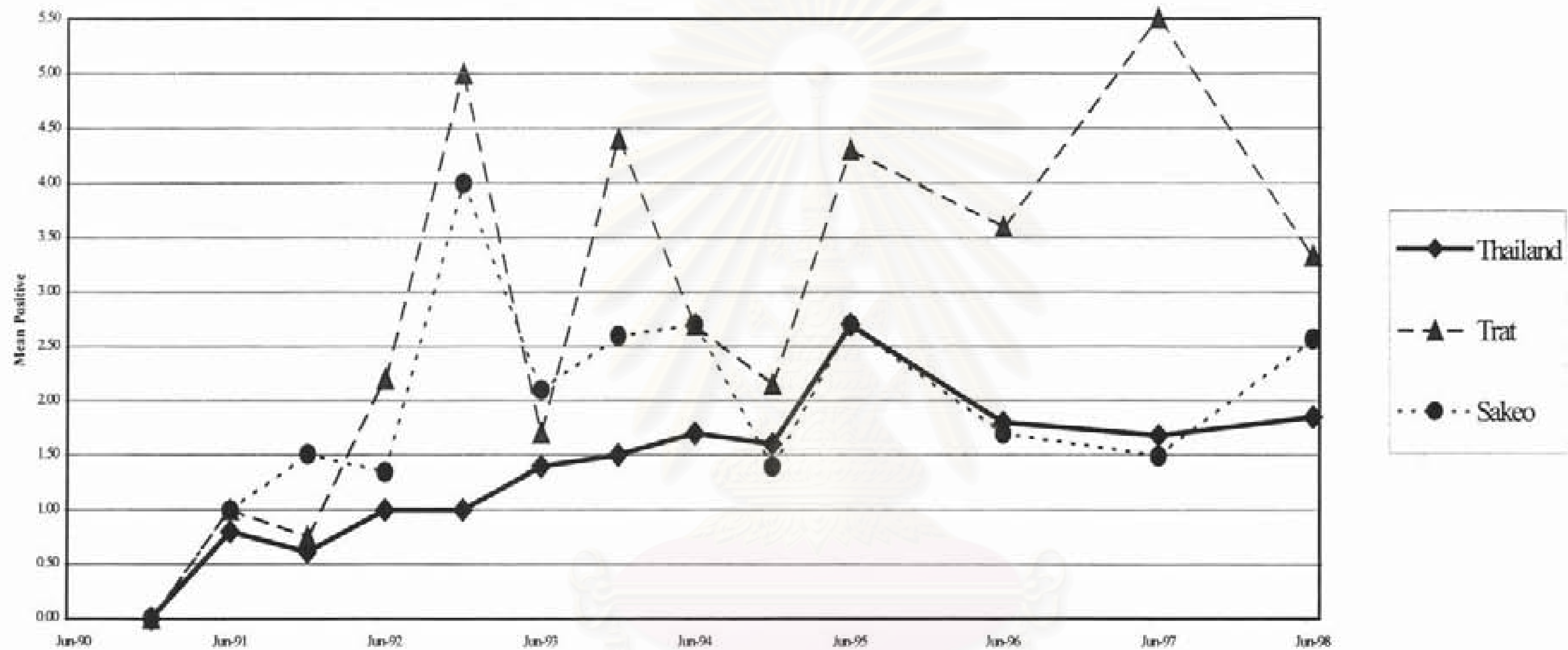

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Table 3.6 Numbers of People with AIDS and AIDS Related Symptoms Sakaew 1993-98

	1993-1994	1995	1996	1997	1998	Total
Full blown AIDS	49	56	100	98	86	389
Symptomatic	30	50	117	92	60	349
Total	79	106	217	190	146	738

Table 3.7 presents statistics for Aranyaprathet and includes additional numbers than what was reported for Aranyaprathet in records from Sakaew, which is most likely Cambodian migrants.

Table 3.7 Numbers of AIDS Patients Treated at Aranyaprathet Hospital

People with AIDS	1994	1995	1996	1997	1998	Total
Men	27	36	59	56	28	206
Women	3	5	20	29	18	75
Total	30	41	79	85	46	281

In 1998 and 1999 the hospital conducted HIV tests for selected migrant workers. In 1998 workers were selected from two districts, namely Aranyaprathet and Ta Praya. A total of 525 workers were tested and 28 or 5.33% were found to be positive. In each district 14 sex workers were also tested, out of the total of 28 tested 18, or 64.3%, were found to be positive. In 1999 627 were tested from four districts and 27, or 4%, were positive. Sex workers were selected from two districts and of 43 tested 11, or 25.6%, were positive.

Table 3.8 Seroprevalence of Migrant Workers in Border Districts, Sakaew Province

District	1998				1999			
	Migrants	No.	+	%	Migrants	No.	+	%
Aranyaprathet	Gen workers	389	19	4.9	Gen workers	260	13	5.0
	Sex workers	14	9	64.2	Sex workers	-	-	-
Ta Praya	Gen workers	136	9	6.6	Gen workers	171	4	2.3
	Sex workers	14	9	64.2	Sex workers	31	9	29.0
Khlong Had	Gen workers	-	-	-	Gen workers	28	2	7.1
	Sex workers	-	-	-	Sex workers	-	-	-
Kingkhoksung	Gen workers	-	-	-	Gen workers	213	8	3.7
	Sex workers	-	-	-	Sex workers	12	2	16.6
Total	Gen workers	525	28	5.3	Gen workers	672	27	4.0
	Sex workers	28	16	57.1	Sex workers	43	11	25.5

3.4 Methodology

Preparation and data collection

Development of the structured questionnaire was undertaken in November 1998 and preliminary research was undertaken at the same time. The survey was conducted in December and a return visit was made in April.

Table 3.9 Dates of Prepatory Work, Training, and Data Collection

Date of visits	Purpose of visits
15 – 16 November 1998	Collection of background information; observation of site; identify collaborating organisations
11 – 12 December 1998	Workshop to discuss ideas and cooperation local organisations; select assistants; testing questionnaire
18 – 24 December 1998	Workshop to train translators and test questionnaire. Collection of data over five days
1 – 5 April 1999	To confirm data and to gain further qualitative data

In addition to the formal survey several key informant interviews were undertaken, five in-depth interviews – four with sex workers, and one a former sex worker now sometimes working as an agent, and several informal group discussions. Some key informants acted as guides over a few days and this included time spent in Poipet.

ARCM staff collaborated with local individuals and organisations to prepare, plan, and implement data collection in the following ways:

1. Planning on-site was undertaken with generous support from personnel at the Provincial Public Health Department, and also at the district office.

2. Data collection was undertaken through personnel, primarily nurses, from two district hospitals, Aranyaprathet and Tapraya, in conjunction with ARCM personnel. The Thai nurses and other assistants were fluent in Khmer language.

3. Security officials and other government personnel facilitated access to migrant workers for interviews to take place.

In addition to the above collaborative work outside consultants were brought in to provide advice on migration, population issues, and HIV/AIDS.

Constraints and limitations

Area of study

The research focus was on Aranyaprathet, rather than across the border, in order to understand the nature of the environment and the risk situation for migrants in Thailand. However, the majority of migrants are daily commuters and thus their residence is in Poipet. Given time and resource constraints it was not possible to access their living conditions and after work activities in Cambodia.

Furthermore, the main risk situation for migrants was in Poipet, given that most migrants left Aranyaprathet late afternoon, straight after work, and given the magnitude of the sex industry there compared to Aranyaprathet. While staff had visited Poipet and undertaken interviews and were accompanied by well informed local officials, more data was needed and this was the main reason for the return visit in April. It was therefore, possible to gain a clearer picture of the area in Poipet, and discuss health and other problems with doctors and others in the township, as well as more keenly observe the border crossings.

While the high risk situation is definitely based in Poipet, there are other areas where risk situations can be found. One area is the farms and plantations in the northeast of the district where seasonal work is available for migrants. There are stories of migrant women being harrassed by migrant men, and of some migrant women working as sex workers.

Representative sampling

The sample in the farming area mentioned above was small, as access to migrants was difficult, for given their illegal status they were fearful of outsiders. Also they were working by day and had to be approached by night which was even more treacherous. Finally with the support of the local sub-district head we were able to gain interviews on three farms. Thus, in the occupational sampling these migrants were underrepresented, particularly as there are other groups on the border of, and in adjoining, districts.

Commercial sex workers were not included in the quantitative survey as they are not generally, or very few are, based on the Thai side, although many travel across to service specific clients and then return. In addition, the sex industry in Aranyaprathet has reduced in recent years and is less accessible. At the time of the survey it appeared that almost all sex workers in Aranyaprathet were Thai.

Language

Many officials and people acting as assistants and translators were fluent in both Thai and Khmer. Training was conducted in Thai but should not have presented any problems. Some constraints can be assumed however, as some of the language, and the meaning, of

the questions can even present some ambiguity or require clarification in Thai in which it was written. Thus despite comprehensive training over two days it is possible that there were some difficulties, hopefully minor ones, and the survey resonses seem to demonstrate that the research instrument had a fairly high validity.

Privacy

Given that some of the questions are of a sensitive nature it was important to maintain privacy in the interviews. Most interviews were held in private in out of the way locations. Mostly small groups came to designated places to undertake interviews. On those occasions it was sometimes necessary to only ask the safer questions when someone else was present and to continue with the other questions later. On a few occasions the structured interviews had to be abandoned, which allowed for informative group discussions.

Questionnaire and sensitive questions

There were a range of questions on sexual behaviour and condom use that were thought to be to sensitive for face to face interviewing, especially as there were often two interviewers, a Thai researcher and the Khmer speaking assistant. A separate questionnaire was developed that could be self-administered in private, mainly by ticking the correct responses. However, only a relatively small sample could be collected in this way due to the high degree of illiteracy among respondents. There were insufficient numbers to provide a reliable analysis and thus this was abandoned. Many of these questions were included in the structured questionnaire for the Trat survey.

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Part II **FINDINGS:**

Migrants and Migration Behaviour

3.5 Demography of the Study Sample

The study sample of 318 respondents is divided into three areas designated as Area 1, 2 and 3, defined according to where the interviews took place. Two areas are border crossings, and which comprises mainly daily commuters, and the third is farming area approximately 10 kilometres inside Thailand. There is a high degree of correspondence with respondents within each specific area and the nature of the work performed, the place of residence, and immigrant status.

Area 1 is the main border crossing, located in the central market of Rong Kluea in Khlong Leuk village, where official border passes are obtained by over a thousand people daily. They may comprise tourists, traders, business people, officials, labourers and other workers, and other local residents, and most must return on the same day.

> The study sample in Area 1 is made up of mainly immigrant traders and labourers who reside in Poipet and cross with official passes.

Area 2 is the designation for the several check points controlled by soldiers or border police and where employers select their workers crossing from Cambodia on a daily basis.

> The study sample in Area 2 is made up of predominantly people who work in rice fields but also other contracted labour. They generally reside in villages across the border, and rather than obtaining border passes are signed for by the employer.

Area 3 is a large farming area approximately 10-20 km inside Thailand where 500-1000 people are employed at one time on a seasonal basis in sugar cane fields, or corn and rice fields.

> The study sample is small, due to difficulty in accessing them, and comprises predominantly men but also some married women. They have crossed the border illegally and stay for the duration of the planting or harvesting period.

Table 3.10 Area by Gender of Respondents

Gender	Male		Female		Total	
Place	No.	%	No.	%	No.	%
Area 1	99	(63.1)	58	(36.9)	157	(100.0)
Area 2	60	(45.8)	71	(54.2)	131	(100.0)
Area 3	24	(80.0)	6	(20.0)	30	(100.0)
Total	183	(57.5)	135	(42.5)	318	(100.0)

Occupation

Most of the respondents, 86.3%, are daily commuters, with 49.4% crossing at the main border check point, Area 1, and 41.2% at various check points along the border, Area 2. The remainder work seasonally in Area 3. Of the 158 respondents crossing at Area 1, 76 are labourers and 61 are traders, with 13 store employees (Table 3.11). In Area 2 and 3, respondents work in agriculture or other contracted labour. The contract labourers from Area 1 are more like petty entrepreneurs, many sometimes pull carts across the border, or are hired for other menial tasks, some may offer services, such as guides into Poipet. Thus, they have more contacts with a range of people than do other labourers or agricultural workers. The labourers in Area 2 have different tasks often involving loading and unloading agricutural and other goods, but they may take on various tasks, and again may have more contacts than agricultural workers. When testing some variables occupational cohorts are sometimes modified to reflect these different characteristics. Sugar cane workers may be grouped with rice field workers, and labourers may be controlled for which Area they come from.

Table 3.11 Occupation of Respondents by Area

	Area 1		Area 2		Area 3		Total	
Occupation	No.	%	No.	%	No.	%	No.	%
Trader	61	100.0	-	-	-	-	61	100.0
Store	13	100.0	-	-	-	-	13	100.0
Labour	76	65.0	38	32.5	3	2.6	117	100.0
Rice field	-	-	90	91.8	8	8.2	98	100.0
Sugar cane	-	-	2	10.0	18	90.0	20	100.0
Other	8	88.9	1	11.1	1	-	10	100.0
Total	158	49.4	131	41.2	30	9.4	319	100.0

Fewer single women are in the sample but the proportions given here of men and women, single and married, may reflect the actual proportions of Cambodian workers in Aranyaprathet. There are many single women in the sex industry of course, however, they generally stay in Aranyaprathet only long enough to provide sexual services or overnight. The structured questionnaire survey was only undertaken on the Thai side, thus sex workers are not part of the quantitative survey sample.

Women are represented in each occupational category in relatively equal numbers except for the proportions in contract labour and in sugar cane harvesting (Figure 3.4). Table 3.12 presents a breakdown of occupation by marital status but gender divisions are not shown. Single and married women are represented in all occupations with relatively similar proportions, except in agricultural work in Area 3 where single women respondents are not represented.

Figure 3.2 Occupation by Gender

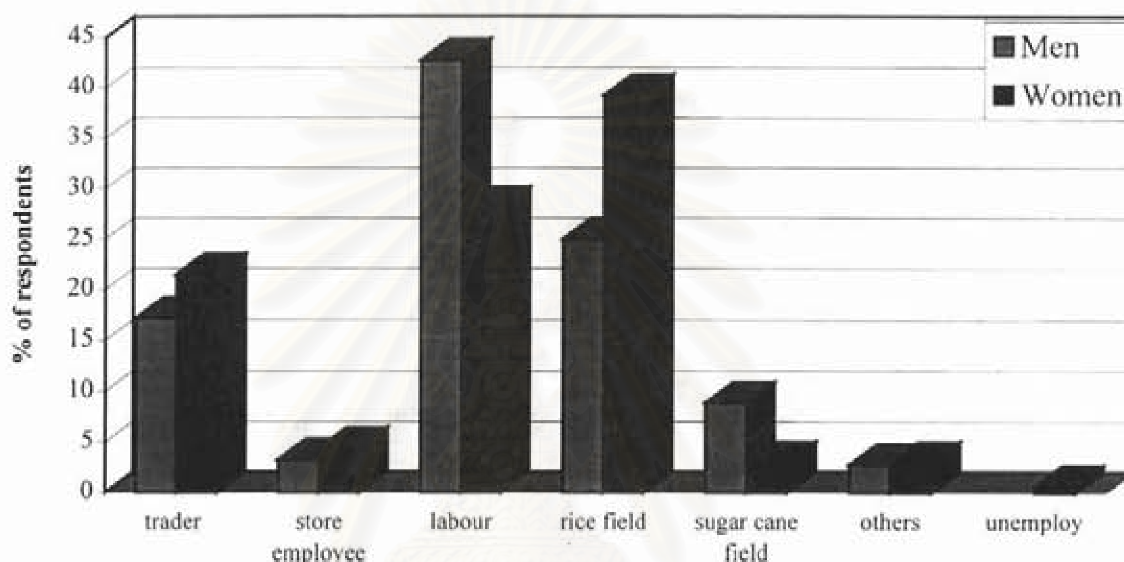


Table 3.12 Occupation by Marital Status

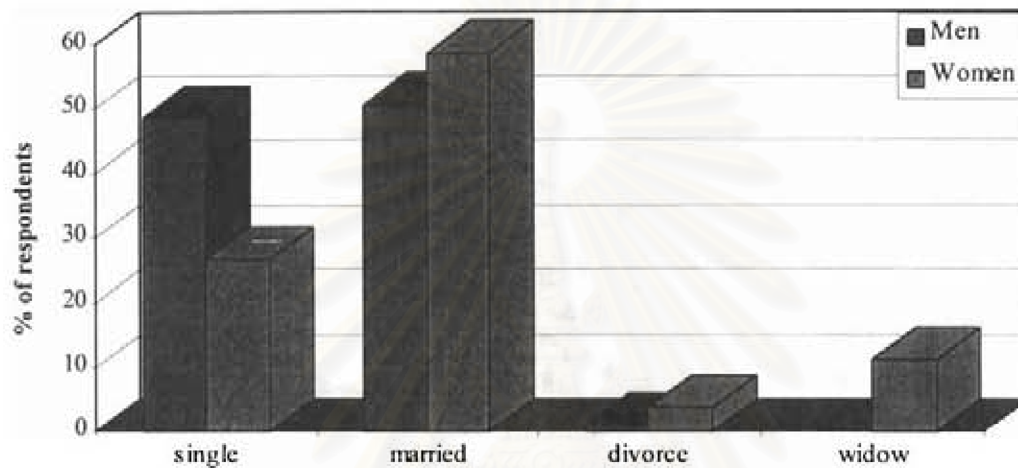
Occupation	Married		Single		Widow		Divorce		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Trader	24	19.2	33	19.4	1	6.7	2	25.0	60	18.9
Store	11	8.8	2	1.2	-	-	-	-	13	4.1
Labour	49	39.2	57	33.5	6	40.0	5	62.5	117	36.8
Rice field	29	23.2	63	37.1	6	40.0	-	-	98	30.8
Sugar cane	7	5.6	11	6.5	1	6.7	1	12.5	20	6.3
Other	5	4.0	3	1.8	1	6.7	-	-	9	2.8
Total	125	100.0	169	99.5	15	100.0	8	100.0	317	99.7

2 single unemployed missing

Marital status

Of the total sample 39.6% are single and 53.3% married with the remainder divorced or widowed. The different proportions are due to fewer single women, 26.7%, compared to married women, 58.5%; as well as the proportion of widowed women, 11.1%, and divorced women, 3.7%. The proportions of single and married men are similar, with 1.1%, or two men, divorced.

Figure 3.3 Marital Status by Gender



Age of Respondents

Within the total sample women men have higher proportions within the younger age groups, distinctly noticable in the 21-30 age group where 43.2% of all men are accounted for compared to only 28.1% of all women. Women have higher proportions among those over 40 years old, 20% compared to men 6.6%. The sample included a wide range of ages from 15-55 years of age. The mean age for men was 26.7 years, and for women it was 30.4 years.

Figure 3.4 Age of Respondents

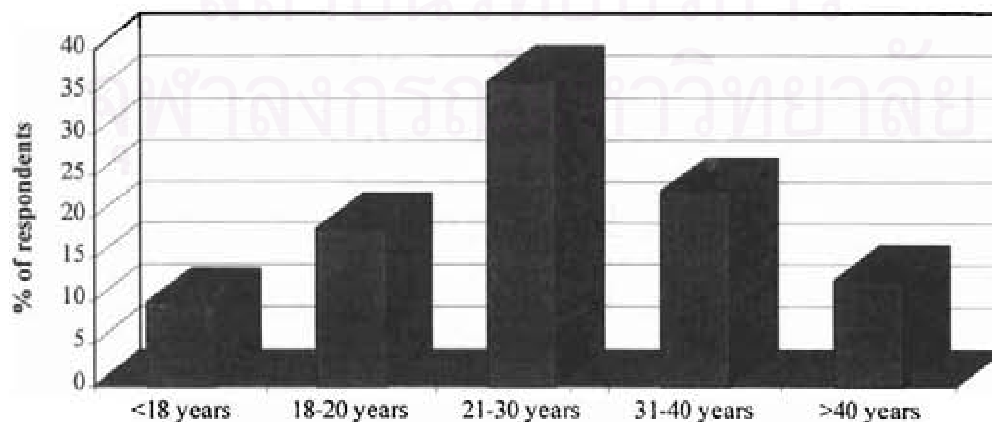


Table 3.13 Age Distribution by Gender

Age	Male		Female		Total
	No.	%	No.	%	
15-20	54	29.5	34	25.2	27.7
21-30	79	43.2	38	32.5	36.8
31-40	38	20.8	36	26.7	23.3
Over 40	12	6.6	27	20.0	12.3
Total	183	100.0	135	100.0	100.0

Education

Educational levels vary from no formal education, 28%, up to the highest level of nine years or more, 13.4% of all respondents. Women are over-represented in the no formal education group, 36.8% of all women, as opposed to 21.3% of all men. They have equal representation, proportionately, in the 1-5 years bracket, but are under-represented in the 6-9 years, 17.3%, compared to men, 23.6%, and in the highest bracket, 9% compared to 16.7%. The mean level of education for women was 3.2 years, compared men who had five years. Among the main occupation groups, traders are the most highly educated, labourers are next, and agricultural workers have very high proportions within the lowest educational levels.

Table 3.14 Education Levels by Gender

Level	Male		Female		Total	
	No.	%	No.	%	No.	%
None	37	21.3	49	36.8	86	28.0
1-5	67	38.5	49	36.8	116	37.8
6-9	41	23.6	23	17.3	64	20.8
>9	29	16.7	12	9.0	41	13.4
Total	174	100.0	133	100.0	307	100.0

It is known that literacy levels are generally low in Cambodia and this may be reflected in the proportion of people who have no formal education or five years and less, 65.8%. Many of those with some formal education may have had interrupted schooling due to civil war and repeated dislocations. Apart from the question on education there is no variable to determine the degree of literacy (also see methodology). However, given that the study sample spend much of their time in Thailand working with Thai employers proficiency in Thai was questioned and used as an important variable in responses on knowledge, attitudes and behaviour.

Thai language proficiency

Over 90% of respondents stated that they cannot write, and 87.7% said they cannot read Thai. Many can speak Thai but 78% have little or no spoken Thai. A similar proportion, 75%, said that they cannot understand Thai, or can only understand a little. The remainder have moderate or good comprehension and speaking skills. These relatively high proportions of little or no Thai language skills indicate that most respondents are migrants who have not been in the area long, or that they have limited contact with the Thai community. Some local people are bilingual in Thai and Khmer; however, this pertains to only a small proportion of the study sample who represent migrant workers. Some of these workers have lived in the border area, or returned to the area many times, for several years, and thus have gained Thai language skills. However, some people who may be deemed 'locals' due to their time in the area during the dislocations of war, or after, may have been captured in the survey sample.

Table 3.15 Skill Levels of Thai Language by Category

Level of Skill	Spoken Thai	Comprehension	Reading Thai	Writing Thai
None (%)	46.7	33.9	87.7	92.7
Little (%)	31.3	41.1	6.3	4.7
Moderate (%)	13.8	15.7	3.8	1.3
High (%)	8.2	9.4	2.2	1.3
Total (%)	100.0	100.0	100.0	100.0

The testing of variables is confined to spoken Thai, which has very similar proportions to comprehension. Reading and writing is of less importance and and the numbers of those with some skills is very low.

Men are only very slightly likely to have better Thai language skills than women. Younger people are more likely to have better skills than older respondents, especially those under 21 years of age. Traders and store employees have much higher skills than labourers and those working in agriculture, who had between 80-90% with little or no skills. There was some correlation within length of stay in the border area with higher proportions of moderate and high skills among those who had been in the area over one year.

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3.6 The Migrant Worker: Behaviour and Working Conditions

Home town and pre-departure

Before moving to the border area, that is, in their previous place of residence, or in their home towns, 48% of the study sample worked in agriculture, another 14% were contract labourers, the remainder were mainly unemployed, 11.5%, students 9.6%, and traders 8.4%.

The majority of the sample, 40%, came from Bantery Meanchey, 16% from Battambang, 9.5% from Siem Reap , and 8% from Kampong Cham (see Map 5). The remainder were mainly from Phnom Penh, Prey Veng, Tekeo and Pursat (Figure 3.7). For 81.4% of the respondents this was their first time they had migrated or moved from their birth village. But this does not include seasonal movement for short term work as this was not included in the survey.

The majority of respondents, 50%, claim to have come to the area on their own initiative, with a further 38% being encouraged by a friend or relative. Only 6.5% mentioned a local employer, in addition 3% mentioned a Cambodian agency and 1.6% a Thai agency. As the great majority of workers are not illegal (only working on day passes) it is not likely they had anything to hide in these responses, thus agencies appear to be a minor concern in the migratory process. Almost half the sample did not have any prior knowledge of the border area or the conditions of work before coming, 49% (Figure 3.8). However, the remaining 51% did obtain prior knowledge from others; 43% of the total sample said that they gained information from friends or relatives. This 43% is close to the 38% who said that they were encouraged by friends or relatives to migrate to the border.

Almost 70% of respondents claimed that many people from their village have come to work in Thailand. This supports the claims that many people have come through recommendations from friends and relatives; and those, mentioned above, who came on their own initiative, may have been enticed by stories from friends and relatives, but then decided on their own initiative to come. Only 26 people knew of someone from their village who had worked in another country besides Thailand.

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MAP 5 Place of Origin of Migrants to Aranyaprathet

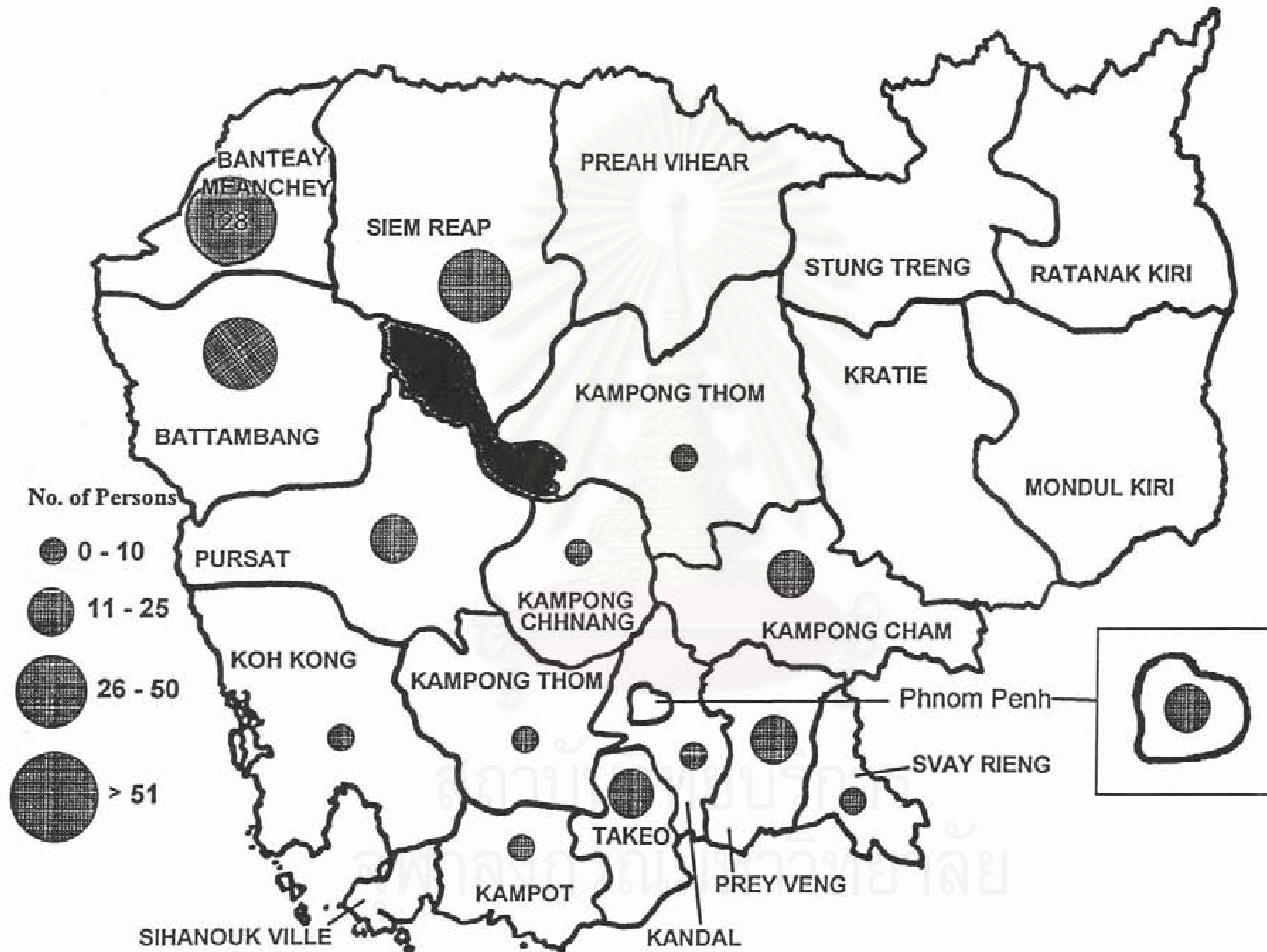
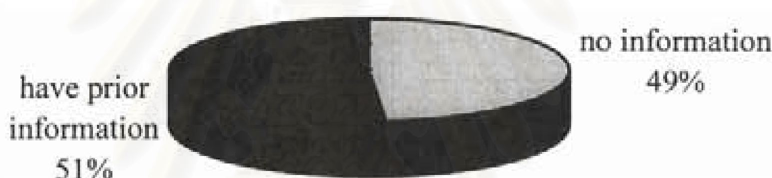


Figure 3.5 Encouragement to Migrate

Figure 3.6 Information Prior to Migrating



Income and savings

Over 90% of the sample receive wages or remuneration on a daily basis, usually from B60-100 per day, and with some fluctuations in work some respondents had difficulty estimating their monthly income. Labourers are sometimes on a piece-meal or intermittent income, but they made an effort to provide approximations of income.

Of those respondents who gave an estimate of their income (n=256), 78.7% earn less than B2,000 per month month. A large proportion were below B1,000, 40.2% of the total sample, and 10.8% earn between B2,000 and B4,000. The remaining10.5% earn over B4,000, with a few earning B30,000 or more.

Women are over-represented in incomes below B2,000, 84.6% of all women compared to 74.6% of men earn below B2,000 (Table 3.16). The mean income of women was B3,024 compared to men with a mean of B3,553 per month. Men earning under B500, 13.1%, and women 1.8%, probably reflects those men being unemployed. Women have relatively equal proportions in the high income brackets due to the earnings of female traders. Table 3.16, showing income by gender, presents the data for income starting from B500; however, for

cross-tabulations with other variables in Part III all categories below B2,000 are reduced to one cohort of low income earners. Thus Table 3.17, presenting income by Area, shows a cross-tabulation using just four income cohorts. Area 1 has much higher earnings than Area 2 or Area 3, mainly due to the particularly high earnings of traders in Area 1.

Table 3.16 Income of Respondents by Gender

Income	Male	Female	Total
<= 500	13.1	1.8	8.1
501-1000	22.8	44.1	32.0
1001-1500	22.8	16.2	19.7
1501-2000	15.9	22.5	18.9
2001-4000	15.2	5.4	10.8
4001-6000	0.7	1.8	1.2
>6000	9.7	8.1	9.3
Total	100.0	100.0	100.0

Table 3.17 Income of Respondents by Area

Income	Area 1	Area 2	Area 3
<2000	65.5	92.9	100.0
2000-4000	15.1	7.1	-
4001-6000	2.2	-	-
>6000	17.3	-	-
Total	100.0	100.0	100.0

Of 24 people earning over B6,000 and some more than B30,000, 22 were traders. Figures 3.10 & 3.11 clearly demonstrate that traders have the highest earnings, however, Figure 3.10 shows the distribution of income cohorts, and demonstrates there are a range of incomes within in each cohort. For example, some traders have low incomes; however, qualitative research suggests that some traders may have been underestimating their income.

Figure 3.7 Income by Occupation

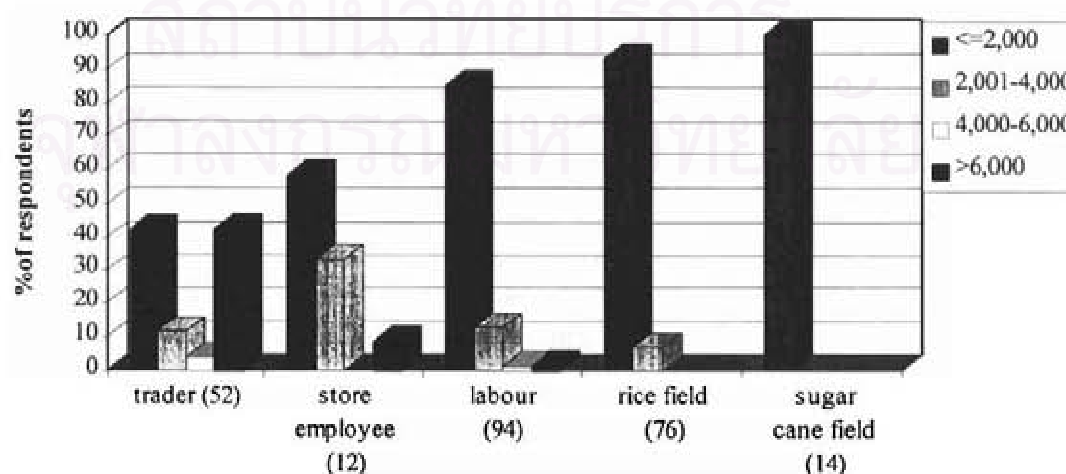
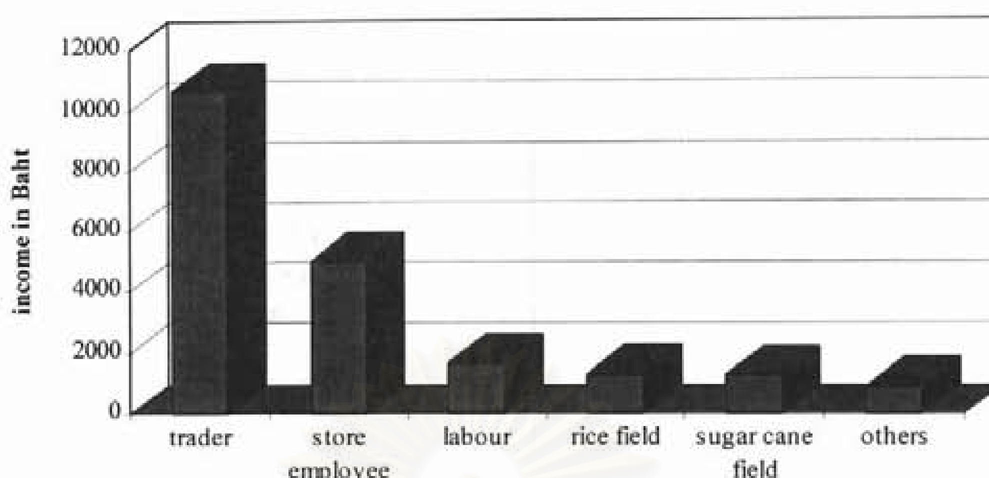


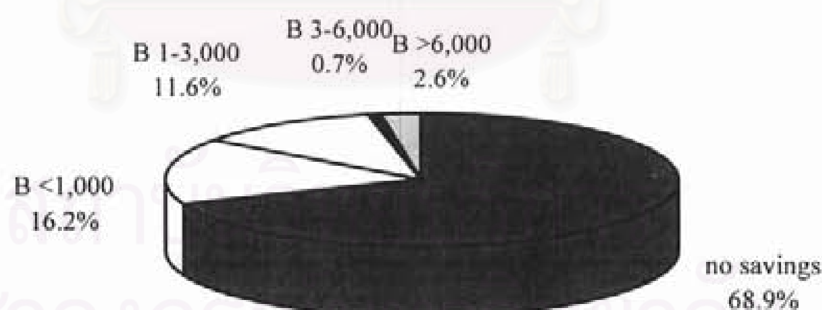
Figure 3.8 Means of Income by Occupation



Savings

Few people are able to save much money, and 69.2% claim to have saved no money. Of those who save money, 52% (n=94), saved less than B1000 over one year, 37% B1,000 to B3,000, and 10.6% over B3,000. Figure 3.12 shows this as a proportion of the total sample, with 16.2% having savings of less than B1,000, 11.6% B1,000 to B3,000, and 3.3% over B3,000. Those on the lower income levels, primarily labourers and those working on farms, are earning significantly lower wages than Thais doing the same work who usually earn between B100-150. However, they are earning far more than they could earn in Cambodia.

Figure 3.9 Savings of respondents



Contact with relatives and sending remittances

Over 95% said that prior to coming to the border area they stayed with family, mostly it seems with extended family, 22.5% said with nuclear family; and 86.2% claimed to have a relative remaining in their 'home' town. The qualitative data suggests that men often came to the area first and later their families followed them. Thus, only 50% of those who said that they had a relative at home had any contact, or occasional contact with such relatives, which is consistent with the percentage of respondents, 49% of this sample, who claimed that they

never, or rarely, went home. When questioned on when their last visit home was, 41.5% said that they never returned, 23% said in the last month, a further 9.4% said in the last two or three months, a further 14.1% in the past 3-14 months, and 6.5% of the total sample said in the last two to six years.

Of the total sample, 21.7% (n=68) returned home regularly, once or twice a year. The majority of these respondents (n=42), were from the main border crossing, Area 1, with some daily commuters at the check points in Area 2 (n=19). Only 7.4% visited home three to six times a year, a total of 23 people (15 from Area 1, 6 from Area 2, 1 from Area3). This is presented in percentages in Table 3.17. In addition, 4.2% returned once or twice per month, these were mainly daily commuters working on rice fields plus some traders. Over 20% of the sample who return home regularly have sex with their spouse on their visits home, these are both men and women, 36 and 32 respectively.

When cross-tabulating 'frequency of visiting home' with other variables the important determinant was between those who had contact with relatives and those who did not, thus, the categories were simplified to 'never/rarely' and 'regular', which were 55.7% and 44.3%, respectively. These are the categories used in the next section on knowledge and attitudes of HIV/AIDS.

Table 3.18 Frequency of Visiting Home by Sub-district

Visiting frequency	Area 1 (%)	Area 2 (%)	Area 3 (%)	Total (%)
Never/rarely	49.0	58.6	78.6	55.7
1-2 x per year	28.1	14.8	17.9	21.7
3-6 x per year	10.5	4.7	3.6	7.4
> 1or 2x per month	2.6	7.0	-	4.2
Every day	9.8	41.4	-	11.0
Total	100.0	100.0	100.0	100.0

Remittances

Further evidence of separation from home or relatives may be that 65.5% said that they have never sent money home which may be consistent with 68.9% of respondents claiming to having no savings. However, there are other reasons for not sending money home, for instance, many respondents already have close relatives with them; 40% of the total sample responded that they currently live with their spouse in a nuclear family, and a further 35% said that they live with their parents (see below).

Of the 34% of respondents who send money home (n=96), most take it by themselves, 80%, while the remainder send via relatives or friends. The value of annual remittances is mostly B1000 or less, 55.2%; but 25% are above B1000 and below B4,000, with 20.8% above B4,000. The proportions of men and women sending money does not differ significantly. Nor does it differ between married or unmarried.

Living situation

Most people are staying within families, the majority being a parent with a spouse and often with children, 40.3%, or as son or daughter living with parents and siblings, 35.6%, and 4.4% live in a compound family. Others live with same-sex friends, 8.1%, or in mixed sex households, 6.6%, and 5% stay alone.

These categories are cross-tabulated with marital status in Table 3.19, and with occupation in Tables 3.20; however, for further cross tabulations, for example, with AIDS knowledge, the categories are reduced to 'family' and 'outside family', which are 80.3% and 19.7% respectively.

Table 3.19 Living with Whom by Marital Status

Living with whom	*Single*	*%*	*Married*	*%*	*Divorce*	*%*	*Widow*	*%*	*Total*	*%*
Family (parent)	8	6.3	113	66.5	1	12.5	7	46.7	129	40.3
Family (child)	74	58.7	33	19.4	5	62.5	2	13.3	114	35.6
Family compd.	6	4.8	5	2.9	1	12.5	2	13.3	14	4.4
Friend,same sex	22	17.5	4	2.4	-	-	4	26.7	26	8.1
Friend, mix sex	7	5.6	10	5.9	-	-	-	-	21	6.6
Alone	9	7.1	5	2.9	1	12.5	-	-	16	5.0
Total %	126	100.0	170	100.0	8	100.0	11	100.0	320	100.0

Table 3.20 Living with Whom by occupation

Living with whom	*Trader %*	*Store %*	*Labour %*	*Rice field %*	*S. cane field %*	*Others %*	*Total %*
Family (parent)	37.7	7.7	46.2	46.4	25.0	-	40.4
Family (chiid)	52.5	69.2	29.1	35.1	5.0	-	35.3
Family compd.	3.3	-	4.3	4.1	15.0	-	4.4
Friend,same sex	3.3	7.7	9.4	3.1	20.0	25.0	8.2
Friend mix sex	-	15.4	6.0	7.2	15.0	12.5	6.6
Alone	3.3	-	5.1	4.1	20.0	62.5	5.0
Total %	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Period spent in border region.

The period spent in the border area is an important variable for testing AIDS knowledge and risk behaviors, and despite some respondents who have returned to the area many times possibly referring to only their last visit, this variable has correlations with questions on HIV/AIDS rather than the total amount of time spent in the border area. Table 3.21 shows

six periods of time to show the variation of time spent in the border region; however, these categories are reduced to only three for further cross-tabulations. Three groups that then make up the cohorts of 'length of stay' are determined by percentile which gives relatively equal proportions of those who have been on the border a short time (3 months), a medium time (3 - 24 months), and long term (over 2 years). The proportion of commuters from Area 2 is higher for the short period, whereas Area 1 commuters have greater proportions for both mid and long term periods. For example, of all people passing the check point at Area 1, 43% have been in the border area over 2 years.

Table 3.21 Length of Stay by Area

Period of time	Area 1	Area 2	Area 3	Total
<3 months	19.7	48.1	60.0	35.2
4 - 6 months	10.2	6.9	13.3	9.1
7 - 12 months	10.8	9.2	3.3	9.4
1-2 years	15.9	10.7	10.0	13.2
2 - 4 years	21.0	8.4	3.3	14.2
>4 years	22.3	16.8	10.0	18.9
Total	100.0	100.0	100.0	100.0

The breakdown on occupation in Area 1 provides another perspective on this in that 50.8% of traders have been on the border for over 2 years compared to 41% of labourers, but 45% of labourers have been on the border for 3 - 24 months. The data suggests then that many of these people have been away from home for a long time and are living in an area known for high risk behaviours for HIV infection, particularly pertaining to commercial sex. The labourers/agricultural workers from Area 2 who live in villages just across the border comprise relatively equal numbers of men and women, whereas the sample group from Area 1, especially the longer term groups, are predominantly men. As will be shown in the section on AIDS awareness there are few correlations with 'length of stay', although when controlling for men only there are more correlations with AIDS knowledge and risk behaviour.

Current Activities and Looking to the Future

Rest and recreation

Respondents were asked to list the activities they usually do for relaxing after work or when there is no work, and to rank them. All respondents gave their first choice, 74% provided two choices and just over 30% provided three choices, in order of preference. The first ranked activity is discussed and tested against several variables. Table 3.22 presents the numbers of respondents for each of the three choices.

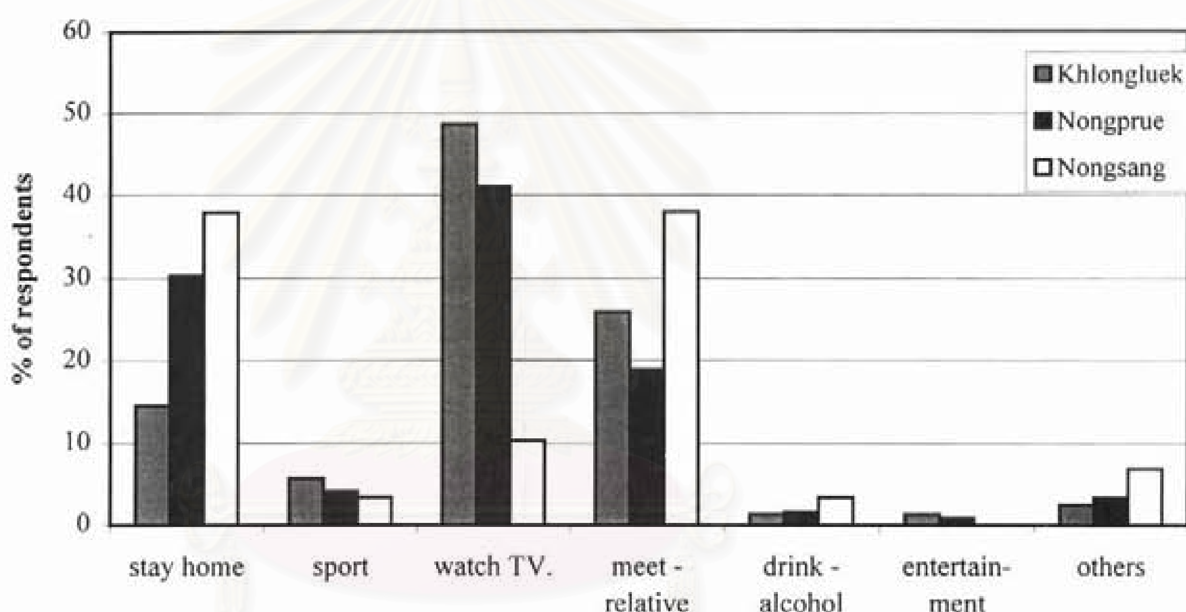
The main form of activity for rest or recreation when not working was watching television, 41.4%, however, others mentioned just 'staying at home', 23.3%, or meeting relatives,

23.9%. Approximately 5% said that playing sport was their main recreation. Only a small number mentioned drinking alcohol although this percentage increased in the second choice.

Women's order of preference, judging by their first choice only, was watching television, staying at home, and visiting relatives. Men's preferences, in order, were similar but visiting relatives came before staying at home. Only men mentioned sport, drinking alcohol, and entertainment.

In Areas 2 and 3 respondents were most likely to watch television, 48.7% and 41% respectively; or 30.3% said stay at home for Area 2, and 25.9% said meeting relatives in Area 1. Area 3 respondents had equal proportions who were most likely to meet relatives, and stay at home, 37.9%; only 10.3% mentioned television, suggesting they may not have ready access to it.

Figure 3.10 Recreation by Area



The above discussion and figure analyses findings from only the first preference of respondents, Table 3.22 presents frequencies in order of first, second and third preferences.

Table 3.22 Rest or Recreation Activities by Frequencies of Preferences

Activity	First	Second	Third
Watching television	130	18	4
Staying at home	71	135	65
Meeting with relatives	75	49	6
Sport	15	21	5
Drinking	5	9	11
Entertainment	3	5	11
Others	10	1	-
Total	322	238	102

Community activities

Few people appear to participate in regular community activities, primarily referring to temple activities which support the temple or celebrate festive occasions and religious holidays. Most respondents, 77.3%, said that they never attend such occasions, while 18% said rarely or occasionally. Only 4.7% said that they did attend or participate regularly. It was difficult to determine any correlations with small proportions, however, those with a higher income, especially over B6,000 were definitely more likely to participate, and men were slightly more likely to say that they participate in such occasions.

Looking to the future

Training or study

Currently 12.4%, or 39 respondents are undertaking some sort of training or study. Questions regarding interest in training or further study evoked a positive response after some encouragement from interviewers. Some respondents were hesitant at first to say what they were interested in but then stated their preferences. Most were interested in Thai language study, 79.6%. Many were interested in learning occupational skills, 31.8%, and English study, 28.5%. Fewer were interested in general study, 10.6%.

Men expressed more interest than women in further study or training. This was particularly true for a preference to study Thai language where 35% of all men stated a preference against 19.4% of all women. There was less difference between men and women's preferences in other categories.

Table 3.23 Respondents Interested in Further Training/Study

Study interest	General study or training %	Thai language %	English language %	Occupational skill %
Yes	10.6	79.6	28.5	31.8
No	89.4	21.4	71.5	67.6
Total	100.0	100.0	100.0	100.0

Plans to return to Cambodia

Most people, 70%, had no plans for the future other than to continue working as they are; 20% planned to return to their homes or away from the border area when they had saved sufficient money; and 6% said they would leave the area when there is greater political stability and peace is assured. Of the total sample, 82% said they would have come to the border area if they knew what they know now, that is, if they could go back in time they would still make a decision to leave their village and seek opportunities on the border. Some respondents in the qualitative survey contradicted this, feeling the opportunities are limited and they would rather have stayed in their village.

Higher proportions of men, 31.1%, than women, 20%, stated their intentions to return, when they can, to Cambodia. The higher proportions came from Area 3, where they are working seasonally.

Attitudes to Thai People

There is reportedly a history of conflict and mistrust among Thais and Khmers in Aranyaprathet which is reflected in discussions with local officials, but only marginally in the migrant's responses to quantitative survey questions. As foreigners in another country, often illegal, and with limited language skills, migrants live with a high degree of insecurity. Poor relations with their hosts, despite shared cultural beliefs, can lead to greater insecurity and heightened vulnerability. It is important to have some understanding of local relations for difficult relations can certainly have an adverse impact on the lives of the migrants.

Only 3.1% of the total sample expressed negative attitudes to Thai people in general. It was labourers and those working on farms in Area 2 and Area 3 that expressed negative attitudes; however, those working on farms, as well as store employees, were more likely to say that they had good relations, rather than fair relations, compared to other groups. There was little difference between men and women although women were less likely to have contact with Thais.

The most positive attitudes were for health officials; however, 50.2% had never had contact with them. Most respondents, 42% of the total sample, stated that they had good relations, with 7.2% saying fair.

Negative attitudes increased when asked about relations with employers, with 5.2% of the total sample expressing such attitudes. However, most respondents said that they had good relations, 57.8%, and only 20.8% said fair, with 16.2% claiming that they never or rarely had contact with Thais employers. There was minimal difference between men and women's responses. Other findings were consistent with the general findings above.

Negative attitudes increased further for attitudes toward soldier/police/border officials, with 17.2% of the total sample expressing negative attitudes. However, 45.9% did state that they had good relations, and 29.3% said fair; 7.6% said that they had no contact with these officials. Women expressed slightly more positive attitudes than men.

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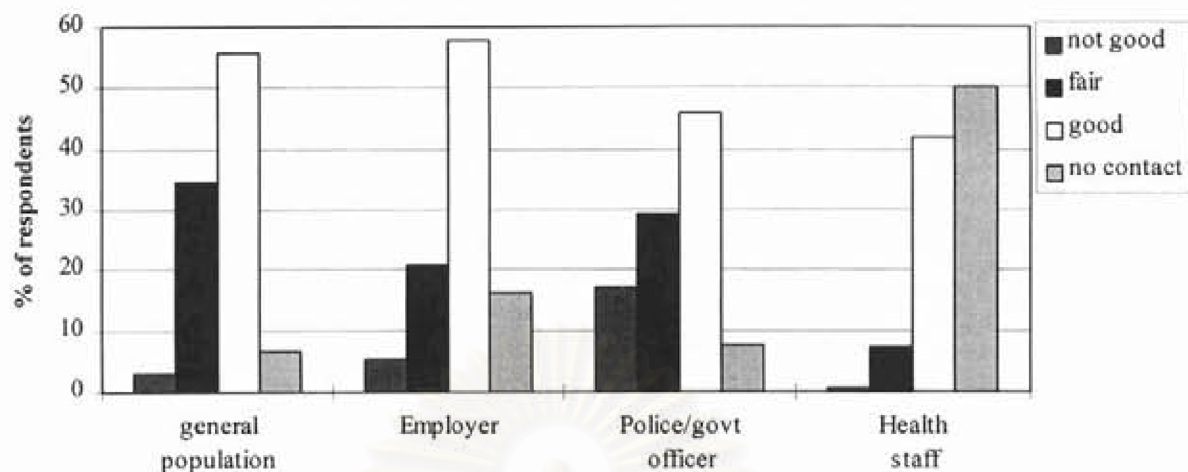
Figure 3.11 Attitudes of Respondents to Thai People



Discussion and Summary

This study was undertaken in December 1998. The research study site is divided into three areas, according to where the formal questionnaire interviews took place. Area 1 is the actual border crossing and there are three occupations represented in the study sample. In order of the highest number of respondents they are: traders, sales clerks, and labourers. Area 2 covers several check-points on the border where Thai employers select workers on a daily basis, the occupations represented are: labourers, and farming jobs in rice fields. Area 3 covers farming areas further into Thailand where workers are employed on a seasonal basis and respondents are mainly working in sugar cane fields.

The study sample is 318 respondents with 183 men and 135 women, 57.5% and 42.5%, respectively. Males are the majority in Area 1, females in Area 2 and males in Area 3. The proportions do not vary greatly, and Areas 2 and 3 include many married couples or family groups. Single men are predominant working in rice fields, and married respondents slightly more predominant among labourers and shop sellers, otherwise proportions are very similar. Single women are represented in all occupations but they are not represented in Area 3.

In the age distribution of the sample men are predominant among the younger age groups, up to approximately 30 years of age, and women are predominant in the older age groups. Of the total sample 28.3% are under 21 years of age, and this only rose to 36.1% for those up to 30 years of age. The mean age for men was 26.7 years, and women 30.4 years.

Women are over represented among those with no formal education and underrepresented in the higher levels of education. Women had a mean of only 3.2 years of schooling compared to men with five years. Over a quarter of all respondents, male and female, have not had any formal education, and a further19.5% have not reached beyond level 3 at school. In all 65.8% have only five years of schooling or less. Fifth level was the end of primary school until the government changed it to six years in 1996 (UNICEF Cambodia).

More than half of the study sample are married, single people make up 39.3% of the sample, and over half of these are living with their parents, some live in other family arrangements, and 30.2% live alone or with friends. Only just over a quarter of all women are single and most live with families. Almost half the male sample is single, never married men, and less than a third live outside of a family. Most migrants have moved as a family unit, either at the same time or following a male member of the family after he has obtained work in the area.

Given this situation of mostly family groups, only 34% of respondents are remitting money home and the amounts are small, mostly less than B1000 per year. There are equal proportions of men and women and married and single respondents who send money home. Approximately half the sample have no contact with relatives in their hometown, of the remainder over half visit once or twice a year and others more often.

Another reason for not remitting money, or small amounts of money is the generally small incomes. Most respondents are paid by the day, earning between B60-B100. Almost 80% of respondents earned less than B2,000 per month, with just over half below B1,000. Traders have the highest income with a mean of over B10,000 per month, and there is reason to believe that these earnings are underestimated. Store employers had a mean of over B4,000 and all other occupation groups are under B2,000. Women's mean eranings were below that of men, B3,024 compared to B3,553, even though there were many female traders with high incomes.

Approximately half the sample worked as farmers before migrating, and the others, in order of highest numbers, were contract labourers, unemployed, students, and traders.
Only 6.5% said they were supported by an employer or agency, therefore most came under the encouragement of friends or their own initiative. Almost half said that they had no prior knowledge of the border area or of working in Thailand.

The data suggests that there are many newcomers coming to the border, with 35.2% stating that they had only been in the area for three months or less. A further 18% had been in the area for less than 12 months. On the other hand 27% had been in the area for two years, and this includes 13% of the total sample stating over five years. Those who had been in the area more than one year had slightly higher proportions in moderate and high Thai speaking skills. Over 20% stated that they have high or moderate speaking skills, but most of these were in Area 1, among the traders and sales clerks. Only 6% said they had good or moderate reading skills. Given that most people are daily commuters, and that they often work and live with other Cambodians the likelihood of enhancing their Thai language proficiency is low, although many stated that they would like to (see below).

In the section on recreation and future plans there were limited numbers of positive responses. For example, the large majority stated that their main recreation was staying at home or watching television. Also 77% of respondents said that they never participate in any temple celebratory activities, or participate in any way in temple activities.

Just over 12% are currently undertaking some sort of study or training, and regards future study almost 80% suggested that they would like to study Thai language. Over 30% said

that they would like to be trained in an occupation, while just under 30% would like to study English.

Only 3.1% of the total sample expressed negative attitudes to Thai people in general. The most positive attitudes were for health officials; however, 50.2% had never had contact with them. Negative attitudes increased slightly for employees and sharply for soldier/police/border officials. This is a very important issue and further qualitative research might tell us more about how good or bad relations are and how this can make migrant workers more insecure and more vulnerable.

Most respondents, 70%, had no plans to go back to Cambodia, and expressed that they made the right choice in coming to seek work opportunities on the border. While this attitude was not shared by all it reflects the poor economic situation which they have escaped from in Cambodia (see Sophal & Sovannarith, 1999). Living and working conditions are difficult for many and resources are few, health services are limited, and exploitation occurs against men and women. However, many are gaining an income and even some savings, thus for many migrants it is a land of opportunity. The question that arises is: what are the health and social burdens that they might bear in order to have some financial security?

Part III **FINDINGS:**

HIV/AIDS and Risk Situations

3.7 Knowledge and Awareness of STDs/HIV/AIDS

This section covers the basic questions of 'ever heard of AIDS' and 'ever heard of STDs', as well as testing knowledge of HIV/AIDS through a range of questions, which includes those of a general nature as well as those pertaining to transmission and prevention, the latter encompasses some common misconceptions.

Method of Analysis

Five areas of HIV/AIDS knowledge were chosen for systematic cross-tabulation, three involved grouping questions together with the use of a scoring system which allowed for comparing means using ANOVA to determine statistical significance. The five areas are as follows:

General knowledge based on two major questions:
1 Can AIDS be cured?
2 Do HIV people have to have symptoms?

General knowledge based on eight minor questions grouped together to compare means:
3 Six questions symptoms of AIDS, plus two on methods of testing for HIV

Knowledge on transmission –
4 14 questions grouped together to compare means and cross-tabulate with variables
nine questions on low and high risk modes of transmission
five questions on misperceptions of transmission

Knowledge on prevention –
5 five questions grouped together to compare means and cross-tabulate with variables

Demographic and migrant behavior variables were systematically cross-tabulated with the above five areas. The 'ever heard of STDs' question is treated as a major question also but is analyzed separately against the same variables. The 'ever heard of AIDS' question is not tested against the same range of variables, extensive analysis beyond frequencies from the total sample was deemed not necessary, thus only demographic variables were cross-tabulated. Associations, statistical or otherwise, are reported for all demographic variables. Only a few of the variables pertaining to migrant behavior proved to have significant or inferential correlations, they are as follows:

- Previous occupation
- Prior information before departure
  - relatively equal numbers who had some information and those who had none

- Regularly visiting home and never/rarely visiting
  - relatively equal numbers of both
- Stay with family or outside family
  - relatively equal numbers who stay with family or friends and alone
- Length of stay
  - period of time in the area, three relatively equal divisions
- Ability for spoken Thai - four divisions: no skills, low, moderate, high

For the remaining sections a range of relevant variables were tested in order to describe and analyse the situation of vulnerability for migrant workers, and for seeking solutions and strategies. These sections include commercial sex, condom use, high risk practices and beliefs, self-reported risk behavior, drug use, acceptable norms of sexual behavior, and attitudes to people living with HIV/AIDS. A range of variables relevant to each context were selected and tested.

In the section below on STDs, correlations are analysed for statistical significance or inferential correlations. Variables that are cross-tabulated are explained clearly in the STD section and appear in specific sequence in order to establish the model of presentation for the following sections on knowledge, transmission and prevention.

Heard of AIDS: through what means

Most people heard of AIDS before coming to work in the border region, 91.6% (n=294). Only 55% had heard of AIDS while in Thailand. When both questions, did you hear of AIDS in Cambodia and 'did you hear about Thailand', were cross-tabulated it revealed that 5%, or 16 respondents, had not heard of AIDS.

In hearing of AIDS before coming to Thailand and since coming men have higher proportions than women. There is no variation in proportions of married or single respondents. Most of those who had been in the area for long periods of time had heard of AIDS while staying in Thailand.

In Cambodia before coming to Thailand TV and radio were the main means of hearing about AIDS, and thus for 63.6% it was what they cited as their main source of information. Gaining information from talking to others was the second major source of information for many, 55.1%. Other sources received much lower ratings: from Cambodian government officer 16.8%; posters 14.6%; newspapers and magazines 13.4%, school teachers 5.6%; NGO officer, 5%. The low rating of written materials reflects a relatively high illiteracy rate.
In Thailand talking with friends is by far the most common means of hearing about AIDS.

Table 3.24 Sources for Hearing About HIV/AIDS: Cambodia and Thailand
(multiple responses)

Through what means	In Cambodia N=294	In Thailand N=173
Talking with friends	55.1	45.6
TV or radio	63.6	15.9
Newspaper/magazine	13.4	1.6
Poster	14.6	6.6
Government officer	16.8	3.8
NGO	5.0	0
School teacher	5.6	1.3

Cross-tabulations of the means of hearing about AIDS in Thailand showed that men are more likely to cite television or radio as their means of hearing about AIDS, 36.3% of those who had heard of AIDS in Thailand, compared with 18.8% of women. A slightly higher proportion of men cited 'talking with friends', and similar proportions cited posters. Those with a higher education were more likely to cite television and radio but this was not significant, and all levels of education had similar responses for 'talking with friends'. That many respondents hear about AIDS through talking with friends suggests that community-based approaches, and the use of peer education, may be important strategies, particularly in this situation where literacy is low, and thus written media is of very limited use.

Table 3.25 Main Sources for Hearing about HIV/AIDS by Education

Heard from where	None (%)	1-5 years (%)	6-9 years (%)	>9 years (%)	Total (%)
Talking with friends	85.7	84.7	86.5	80.0	84.8
TV or radio	22.9	22.2	29.7	55.0	28.0

Heard of STDs: comparing variables – demographics and migrant experience.

From the total sample, 40% claimed to have never heard of STDs. If such a high proportion of people have not heard of STDs then it follows that many people will not be prepared to seek out appropriate treatment or advice when infected. There is evidence throughout the world that STDs facilitate the spread of HIV and appropriate diagnosis and treatment of STDs is the means to combatting the spread of STDs and contributing to slowing the spread of HIV. The high incidence of STDs and the resistant strains that are now occurring in Poipet is serious cause for concern. Increasing condom use and general outreach and counselling by MSF may assist in containing the situation; however, given the mobile populations, especially in regard to the turnover of sex workers, the situation may still be of serious concern.

While there is no significant association between the variables of education and ever heard of STDs, those with no formal education are the least likely to have heard of STDs, 50% of these respondents had heard of STDs. Those most likely to have heard of STDs are from those with higher levels of education, 65.5%.

Table 3.26 Ever Heard of STDs by Education

		None	*1-5 years*	*6-9 years*	*>9*	*Total*
Have you ever heard of STDs	*No*	60.0	42.4	32.5	38.2	41.6
	Yes	40.0	57.6	67.5	61.8	58.4
Total		100	100	100	100	100

There are significant correlations with age where the youngest and oldest age groups having the lowest proportion of respondents who have heard of STDs, 45.5% and 47.4%, respectively. The other two age cohorts 21-30, and 31-40, have high proportions of respondents who had heard of STDs, 64% and 72.6% respectively. Cross tabulations with marital status confirmed that married people are more likely to have heard of STDs than single people, which is consistent with most younger people not having heard of STDs and not being married. There is a significant relationship between men and women with 66.9% of all men having heard of STDs compared to 48.5% of all women.

Traders and labourers are more likely to have heard of STDs than other workers but there is no statistical significance. The difference was similar to that of Area 1, where 63.8% had heard of STDs, compared to Area 2, 55.4%. The income variable further clarifies the situation as Area 1 is associated with occupations of higher income, such as traders. Only 52.8% of those earning under B2,000 are aware of STDs compared to 81.5% of those earning over B2000.

Figure 3.12 Ever Heard of STDs by Income of Respondents
Ever Heard of STDs by Area of Respondents

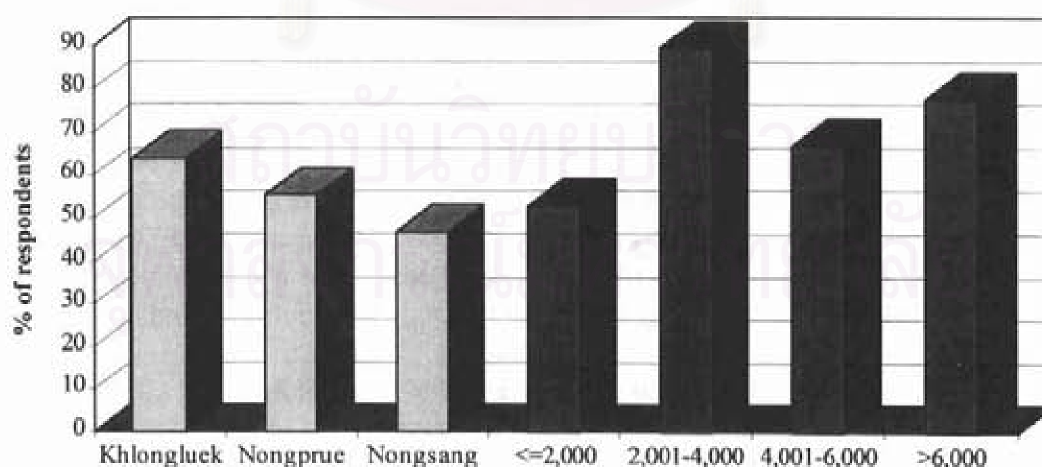
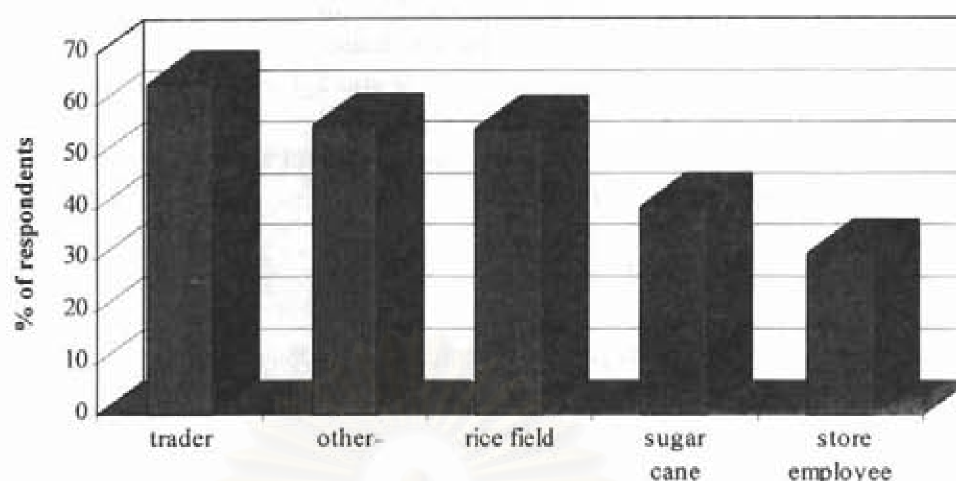


Figure 3.13 Ever Heard of STDs by Occupation of Respondents



Those who had acquired general information on the border area, or on working in Thailand, before migrating, have higher proportions who have heard of STDs than those who had no prior information, 65.4% compared to 50.3%. There is no correlation with previous occupation before migrating.

Those who have been in the area the longest are more likely to have heard of STDs; 67% of those who had been in the area over one year have heard of STDs, compared to 46.3% who had been in the area from 4-12 months, and 46.8% of those from 1-3 months.

Those respondents who regularly visit home are more likely to have heard of STDs, 66.4% of the sample who return regularly, as opposed to 55.% who do not visit, or rarely visit, home.

Of the smaller proportion of people who live alone or with friends, compared to those who live with their family, most of them have heard of STDs, 66.1%. The proportion of respondents living in families who have heard of STDs was 57.8%.

General Knowledge: cure/symptoms/testing

General knowledge, as described above, utilises two questions, and then several more questions which are grouped into one, and covers areas related to the respondent being aware of six AIDS symptoms and three means of testing for HIV. These are treated as three questions in that the third grouping is in effect given the same weighting as the first two questions, and thus there are three items testing different aspects of knowledge, as follows:

1 Can AIDS be cured?
2 A person who is HIV positive does not necessarily have any symptoms?

3 What are the symptoms for HIV infection?

Six symptoms were given, one at a time, yes/no/not sure responses recorded.

What are the testing methods for detecting HIV?

Three possible methods of testing and agree/not agree/not sure recorded.

Questions in item 3 were given scores of 1 for all correct answers and the means was determined for comparing through ANOVA.

1 Can AIDS be cured?

Most people believe that AIDS cannot be cured but a 20% response rate saying that it can be cured, plus almost 20% not sure, suggests that many people are still not clear on the threat of HIV/AIDS.

The youngest age group have the highest proportions of correct responses, 64.4%, but only marginally higher than other groups with the oldest age group having the lowest, 57.5%%. With marital status there is no significant correlation; however, single people have more knowledge than married people, 68.8% opposed to 57%.

There was a significant correlation with education where those with over 9 years of schooling have the highest proportion of correct responses, 81.3%. The cohorts of 6-9 years and 1-5 years have higher proportions, 64.1% and 66.1%, respectively, compared to 44.8% of those with no formal education. Those with a high level of skills in spoken Thai are most likely to respond correctly.

Table 3.27 Can AIDS be Cured by Education

Education level		None (%)	1-5 yrs. (%)	6-9 yrs. (%)	>9 yrs. (%)	Total (%)
Can AIDS be cured?	No	44.8	66.1	64.1	81.3	61.2
	Yes	18.4	20.0	23.1	12.5	19.6
	Not sure	36.8	13.9	12.8	6.3	19.2
	Total	100.0	100.0	100.0	100.0	100.0

There are no correlations with occupation; however, Area 1 and Area 2 has significantly higher proportions of correct answers compared to Area 3. There is no significant relation with income; however, respondents with the lowest income have the smallest proportion of correct responses, 57%, gradually rising to those with the highest income who have 88.9% with correct responses.

Figure 3.14 Correct Responses to 'Can AIDS can be cured' by Income of Respondents Correct Responses to 'Can AIDS can be cured' by Area of Respondents

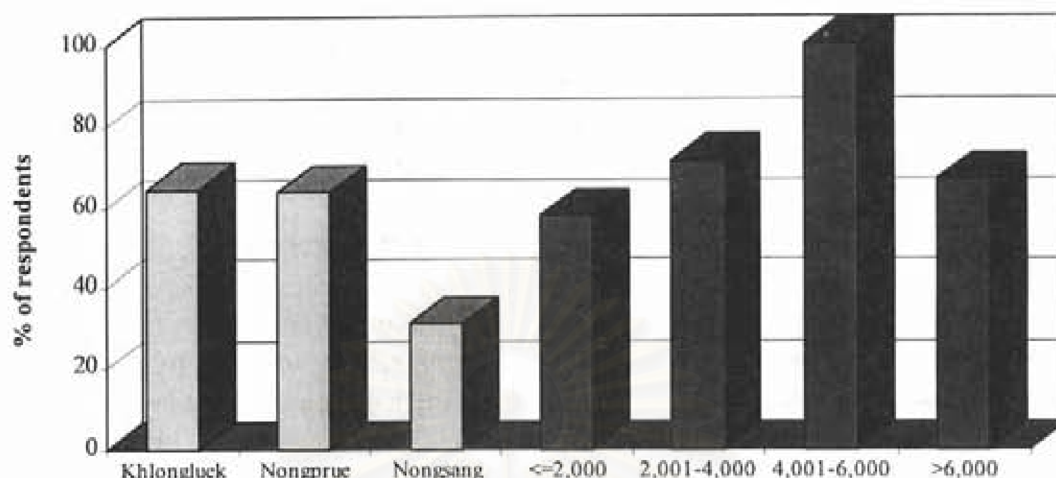
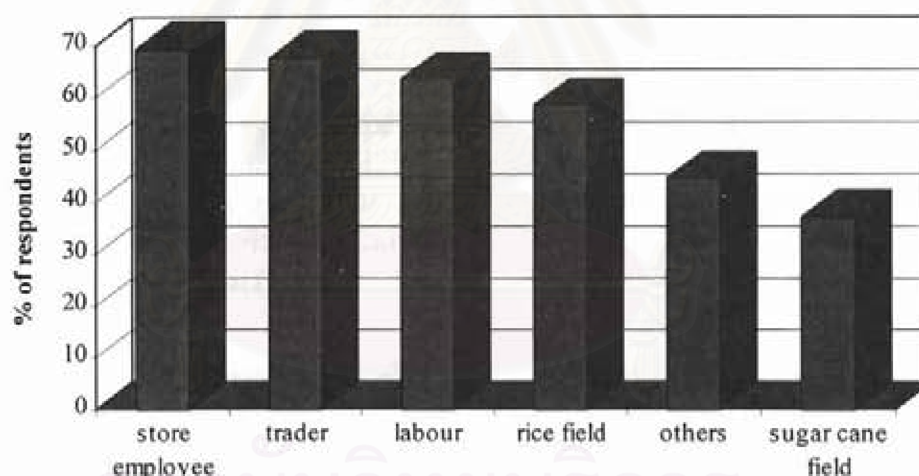


Figure 3.15 Correct Responses to 'Can AIDS be cured' by Occupation of Respondents



Of those who had some prior information before coming to Thailand, 62.7% responded correctly, with 16.8% not sure/don't know. This was marginally higher than those who did not have any information, 58.6%, with 22.4% not sure/don't know.

Those who were previously working as labourers and 'others' in Cambodia have higher proportions of correct answers than farmers, 67.4% and 66.9%, respectively, compared to 54.5%, and farmers also have much higher don't know responses.

In regard to length of stay those who have been in the area 1-2 years have the highest proportion of correct responses, 71.4%, followed by 4-6 months, 64.3%, and 1-3 months 60.7%, 7-12 months, 60%, and over 2 years, 55.2%.

Those who regularly visit home have higher rates of correct responses, 69.2%, compared to 54.9%, and the latter have more don't know/not sure responses. Those who stay alone or with friends, rather than in a family, have a marginally higher proportion of correct responses, 66.1%, compared to 60.1% of those who stay in a family.

2 Do HIV positive people necessarily have symptoms?

On the important question of whether infected people may not necessarily have symptoms, the incorrect response and not sure/don't know responses, 25% and 45% respectively, suggest a high degree of confusion. This has always been a difficult question for people with limited knowledge as they rarely distinguish between HIV and AIDS, which has implications for prevention but especially for care and acceptance of HIV positive people.

The proportion of single people with correct responses is higher than married people, and higher than divorced and widowed. The proportion of the youngest age group with correct responses, 33.7%, is higher than other age groups; decreasing incrementally to the oldest age group, with 20% having correct responses. With regard to gender, 37% of all males answered correctly compared to 21.6% of women, and women have far more don't know/not sure responses.

Once again there are significant correlations with education. The highest proportion of correct responses are with respondents who have over 9 years of schooling, 40.6%, followed by 1-5 years, 37.7%. However, those with no formal education are similar to those with 6-9 years, 24.4% and 23.1% respectively. Those with no formal education have higher don't know/not sure responses. There is no correlation with Thai language skills.

Table 3.28 Do HIV+ People have to have Symptoms by Education

Education level		None (%)	1-5 yrs. (%)	6-9 yrs. (%)	>9 yrs. (%)	Total (%)
HIV+ person must have symptoms?	No	18.6	26.3	30.8	18.8	24.5
	Yes	24.4	37.7	23.1	40.6	30.6
	Not sure	57.0	36.0	46.2	40.6	44.8
	Total	100.0	100.0	100.0	100.0	100.0

There are no correlations with occupation, nor with Area. There are no significant correlations with income; however, those on the lowest income are slightly more likely to answer incorrectly, and they have far higher don't know/not sure responses.

Figure 3.16 Do HIV+ People have to have Symptoms by Area
Do HIV+ People have to have Symptoms by Income

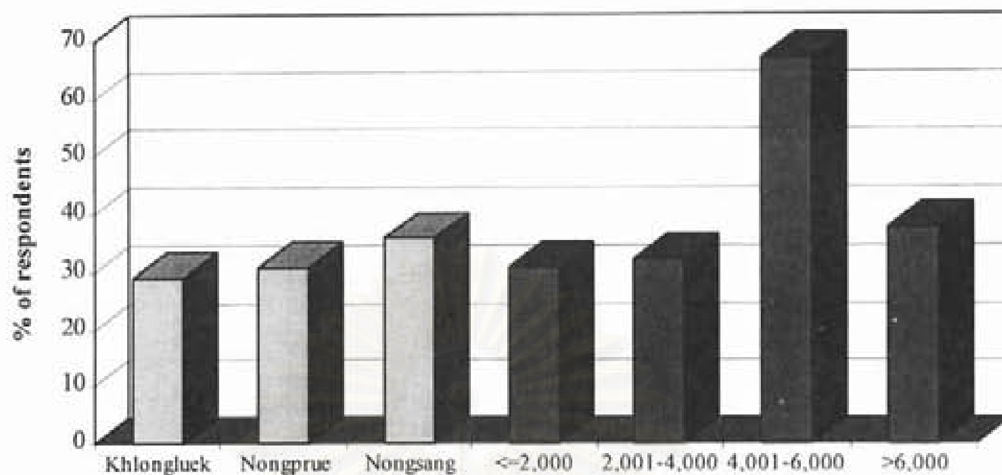
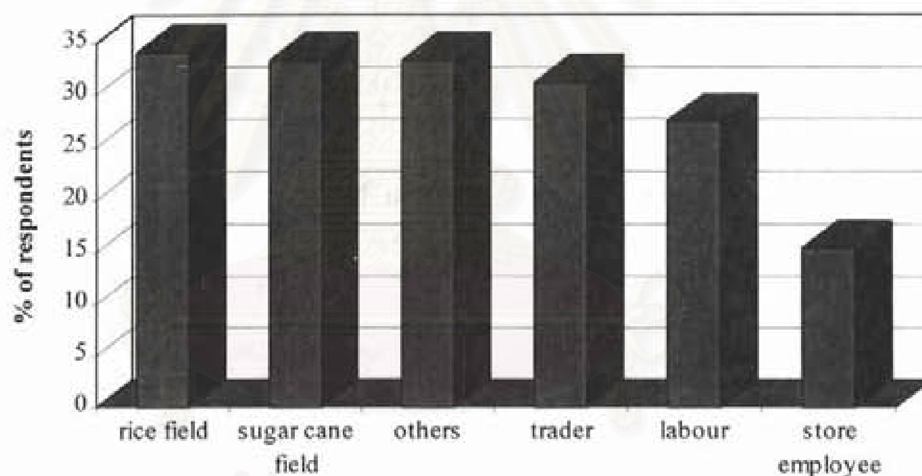


Figure 3.17 Do HIV+ People have to have Symptoms by Occupation



There are no relevant correlations between those who had no prior information before coming to Thailand and those who had some information. In regard to previous occupation in Cambodia there is minimal variation between farmers, labourers, and 'others'.

In regards to 'length of stay' those respondents who have only been in the area 1-3 months, have low proportions of correct answers, 27%, and they hadve the highest rate of don't know/not sure responses, 49.5%. The cohort of 7-12 months has the lowest rate of correct responses, 23.3%. the highest proportion of correct responses was 4-6 months, 37%, followed by 1-2 years, 35.7%, and over two years, 30.5%.

Those who regularly visited home have the highest proportion of correct responses, 35.6%, compared to those who did not visit, 26.5%, and the latter have much higher don't know responses. There is a significant association with the question 'who do you stay with'. Of those who stay alone or with friends, 41% answered correctly, compared to 27.3% of those who stay with families, and the latter has more more don't know/not sure responses.

3 Symptoms of HIV/AIDS and testing methods for HIV

On the symptoms of HIV/AIDS 70% of respondents could answer correctly when asked if a specific symptom was associated with HIV/AIDS. On the testing methods for HIV only 40% responded correctly, although 74% of people identified blood testing as a proper method for detecting the presence of HIV.

In order to analyse these findings in terms of demographics and migrant behaviour a score of 1 was given for each correct response. Means was then tabulated through ANOVA to determine significant differences of several variables with the correct responses on symptoms and tesing. The same procedure is used for knkowledge of transmission and prevention below.

There is a significant difference in rates of correct responses with those with no formal education and all other education cohorts who have much higher proportions of correct responses. Those with over 9 years of schooling have the highest. Those with no ability to speak Thai have the lowest proportion of correct responses and this is significantly low with those who had moderate skills.

Males have significantly higher response rates than females, and single people have significantly higher rates than married people. The oldest age group has a significantly lower proportion of correct responses than all the younger cohorts.

While there is no significant relationship between income cohorts, although those with the lowest income have the lowest proportion of correct responses, and the highest income cohort has the highest proportion of correct responses. Traders and store employees have the highest proportions with correct responses among the occupational groups, and there is a significant difference between Area 1 and Area 2, with Area1 having much higher rates of correct responses.

There is no correlation between those who hadve prior knowledge and those who do not. There is no statistical difference regarding previous occupation, however, farmers have the lowest scores compared to labourers and others.

There is no statistical correlation with 'length of stay', but there is a noticeable gradation from shortest to longest stay with lowest to highest rates of correct responses, except for those over two years. The cohort of 1-3 months has much lower than 1-2 years cohort, which has the highest rate, and still lower than those over 2 years

Respondents who visited home often have statistically higher scores than those who do not. There is no significant correlation with those who stay with families and those who do not; however, there is a noticeably higher proportion of respondents who answered correctly from the group who do not stay with a family.

Knowledge of Transmission

Being able to articulate the transmission routes of HIV/AIDS indicates an understanding of how HIV is spread; however, often it is misleading as people can recall from the media the main forms of transmission without necessarily having a clear understanding of modes of transmission and how HIV actually spreads through the population. And despite knowing the main forms of transmission people may still be confused about casual contact and transmission of HIV.

The results of the survey suggest that almost half of the sample have serious misunderstandings regarding the casual transmission of HIV. Such misunderstandings may be perceived as logical conclusions, or assumptions that people make. They draw these conclusions from their knowledge of communicable diseases, and from some traditional beliefs, however, these conclusions lead to misconceptions in regard to HIV/AIDS and arouse fear. These misconceptions were once common in Thailand and have occurred throughout the world. Misunderstandings on how HIV is spread have to be challenged if fear, leading to stigma and rejection of people with HIV/AIDS, is to be reduced.

From Table 3.29 it is clear that high proportions of people have some fear from their beliefs in how HIV can spread. From touching an infected person, to sharing drinking glasses or cups, to sharing toilets there is an incremental rise to almost half the sample that believes HIV is readily transmitted by these means. With the don't know/not sure responses of 13.8%, 12.5%, and 17.5% respectively, less than 50% of the sample could provide correct responses, 51.4%, 44.7% and 36.9%.

Add to this the high response rate for mosquitoes spreading the virus and it is likely that people's misconceptions lead to confusion over what are the real risk behaviours and risk situations. Kissing is included here for Table 3.29 only includes how HIV is *not* transmitted. Even though an exchange of saliva may occur through deep kissing it is very unlikely to transmit HIV. For this same reason contaminated blood with intact skin is included, as skin is a barrier to transmission. Thus all responses that agree with any of the questions are incorrect.

Table 3.29 Misconceptions in the Transmission of HIV

Possible modes of HIV transmission	Agree (%)	Disagree (%)	Don't know(%)	Total (%)
Touching	34.8	51.4	13.8	100.0
Sharing glasses	42.8	44.7	12.5	100.0
Sharing toilet	45.6	36.9	17.5	100.0
Sharing clothes	40.9	40.6	18.4	100.0
Blood with intact skin	65.5	23.2	11.3	100.0
Kissing/saliva	55.3	21.1	23.6	100.0
From mosquitoes	70.5	18.8	10.7	100.0

There is a relatively high proportion of correct responses in regard to the main modes of transmission. Most respondents are clear that heterosexual sex and sharing needles are the main modes of transmission, along with receiving blood, as in blood transfusions. However, fewer respondents are clear on homosexual sex and anal sex as risky behaviours. This may be due to cultural/social beliefs or may be determined by what the study sample has been exposed to. Unprotected, anal penetrative sex is certainly very risky and should be recognised as such. It may be that the education/information that the study sample has been exposed to has not included homosexual practices nor anal sex. Most of the practices listed in Table 3.30 are potentially high risk; however, oral sex may only contain some risk if there are lesions in the mouth that allows seminal fluid to contact blood. Similarly, sharing razors becomes risky only when a razor has contaminated blood and is used soon after being contaminated and then contacts with blood of the other person. Thus all responses that agree with the question of whether HIV can be transmitted in these ways are correct.

Table 3.30 Knowledge of HIV Transmission

Possible routes of HIV transmission	Agree (%)	Disagree (%)	Don't know (%)	Total (%)
Male-female sex	90.0	2.8	7.2	100.0
Sharing needles	90.9	2.2	6.9	100.0
Receiving blood	87.2	3.5	9.3	100.0
Anal sex	69.8	5.1	25.1	100.0
Male-male sex	59.1	14.4	26.6	100.0
Oral sex	59.0	13.6	27.4	100.0
Sharing razor	84.9	4.4	10.7	100.0

The means of correct responses was tabulated through ANOVA to determine significant differences of several variables with the correct responses on modes of transmission, as described above on general knowledge.

There are significant differences between age cohorts with the cohorts of 21-30 and 31-40 having higher correct rates than those over 40 years old. Men have significantly higher awareness than women. There is little difference between single and married men, nor is there much difference between married and single women; divorced and widowed women have lower scores.

There is a significant correlation among those with no formal education and all other educational cohorts who have much higher proportions of correct responses, especially those with over nine years of schooling. Those who could not speak Thai are the most likely to have incorrect answers and this is significant both with those who have moderate and high Thai speaking skills.

There is no statistical significance between income cohorts but there is an incremental increase in scores from the lowest income to the highest income. This is further confirmed by traders (n=61) consistently scoring higher than other occupational groups (statistically significant with rice farmers, n=98), and with Area 1, where the traders come from, having significantly higher scores than Area 2.

Respondents who have information before coming to Thailand have higher proportions of correct responses than those with no information. In the question on previous occupation there is a significant difference between farmers and 'others', with farmers having smaller proportions with correct responses, and they have smaller proportions than labourers as well.

In testing for length of stay there is no significance among cohorts but through controlling for men only there is a significant difference between the most recent, 1-3 months, and those who have been in the area longest, over two years. There were noticeable differences between 1- 3 months compared to 4- 6 months and 1-2 years but these are not significant.

Those respondents who return home regularly have significantly higher proportions of correct responses than those who do not. There is no correlation between those who stay with families and those who do not.

Knowledge on Prevention

A number of common myths in the prevention of HIV are explored in the questions in this section. While 71.9% responded that condoms can prevent HIV infection the fact that 10.6% said that condoms do not offer protection (and 17.5% were unsure/don't know) is of concern given the high prevalence of sex work. The first real myth however, is in regard to the question of whether choosing a healthy and clean looking person to have sex with offers some protection. It is of concern that 33.2% of respondents suggest that selecting such women (mainly pertaining to CSWs) does offer protection, and 23.8% are not sure.

Negative and affirmative responses to whether condoms are necessary with partners who are not sex workers is identical with 41.3% for each, and 17.5% not sure. This suggests a lack of

understanding of how HIV spreads which in Thailand at least has been common given the emphasis on brothels and sex workers as the vectors of HIV spread.

Alcohol is often associated with drinking and the myth explored here is whether drinking alcohol before and after sex is protective against HIV. Another myth, explored here is that if a man uses the withdrawal method before orgasm then he will be protected from infection.

The final myth which has been common in the past among some sex workers is that if one is tested every three months for HIV does this offer some protection. Almost half, 49.2%, suggest that testing can offer protection, and 32.9% were unsure.

Table 3.30 Prevention Practices and Misconceptions

Practices and beliefs that are protective against HIV	Yes %	No %	Don't know %	Total %
Using condoms	71.9	10.6	17.5	100.0
Selecting healthy looking person	33.2	42.9	23.8	100.0
Sex with person who is not CSW	41.3	41.3	17.5	100.0
Withdrawal before ejection	34.9	33.7	31.4	100.0
Alcohol before and after sex	17.2	50.9	31.9	100.0
Regular blood tests for HIV	49.2	17.9	32.9	100.0

The means of correct responses was tabulated through ANOVA to determine significant differences of several variables with the correct responses on prevention, as described above on general knowledge.

Men have statistically significant higher scores than women. Single men have significantly higher scores than married men. Divorced and widowed women had higher scores than single and married women.

Age is significant in the same way as it was for transmission, with the 21-30 and 31-40 cohorts scoring significantly higher than the over 40s. The under 21s have lower but similar scores to the two cohorts above them. This suggests that those who most need the information are gaining a better understanding of the risk situation. Educational levels are significant for those with no formal education compared with years 6-9 and over nine years of schooling; and 1-5 years also have higher proportions of correct responses compared to those with no formal education. There is no significant correlation with the ability to speak Thai, however those with no Thai have distinctly lower rates of correct responses than all other cohorts.

Again, traders and Area 1 have the highest proportion of correct responses but there is no statistical significance. There is no statistical significance with income but there is an incremental increase in scores from the lowest to the highest income, with the highest income earners having better knowledge than those earning B2,000 or less.

Those who have prior information before coming to Thailand have only slightly higher numbers proportionately than those who had no prior knowledge. In regard to previous occupation, 'others' have higher proportions of correct responses than farmers and labourers, however, there is no statistical correlation.

In terms of length of stay the statistical significant findings are through cross tabulations with men only, as with transmission above. In this case the significance is between the most recent, 1-3 months, and two other cohorts; namely, the next most recent, 4-6 months, and those who have been in the area longest, over two years. The cohort of 1-3 months has much lower proportions of correct responses.

Among respondents who vistit home regularly there were higher proportions of correct reponses than those who do not, although it is not significant. There is little difference in the responses of those who stay with families and those who do not.

Discussion and summary

In comparing correct responses on all the three areas covering general knowledge, and two more areas covering knowledge of transmission and prevention it is consistently significant for men to have higher proportions than women. Single respondents have distinctly higher proportions of correct responses than married respondents, in four of the five areas tested. In two areas, namely 'knowledge on symptoms and testing' and 'knowledge of prevention', the results are significant.

Younger people are certainly more informed than older people but the main difference is between those under 40 years of age and those over 40. In education those respondents with 'no formal education' consistently have lower proportions of correct responses compared with other educational cohorts, and the differences is significant in three of the five areas tested. The highest educational cohorts generally are likely to have more correct responses than those cohorts in the middle range, and significance is demonstrated in two of the five areas.

There were few surprises in analysing for correlations with demographic variables and HIV/AIDS awareness. Men being more informed than women is a facet of men having greater opportunities in education, in work, and having contact with a wider network of people. Women generally have lower standards of education and in this study sample this is the case, and the correlation between low education and low HIV/AIDS awareness is thus pertinent for women.

Women have lower incomes than men, and with income there is clear correlations with lower incomes and less awareness. With occupation the correlations are less clear but quite distinct with traders having the highest proportions of correct repsonses and agricultural workers the lowest. Finally the correlations with Area 1, which mainly comprises traders and labourers, and Area 2 and Area 3, are clearly in favour of Area 1 in four of the five areas of knowledge tested.

Migration variables selected were chosen from those variables which demonstrated some consistency in either significant or inferential correlations. The following discussion summarises the correlations with each of these variables against the five areas of knowledge of HIV/AIDS.

Most people stay in families, but in testing proportions of people for HIV/AIDS knowledge those who stay alone or with friends are more likely to have higher than those in families. They also have slightly higher proportions who have heard of STDs. It is generally thought that single, never married people, staying alone or with friends, and thus free of social controls of home and influenced by peer pressure, may have more risk behaviours than others; thus it is perhaps a positive finding. However, married people are not free of risk, and 'ever married' men living alone are not free of risk. While men generally have more knowledge than women, most male respondents, married, single, or living alone, did not demonstrate good knowledge of HIV/AIDS.

Generally, it appears that many men have travelled to the area first and are later followed by spouse and/or family. This is important in that families can provide support and reduce vulnerability. However, in the study sample over 50% of the men are single, 93 men, which suggests that in the general area there is a large population of single men. Many of these men; however, live with their parents or extended kin.

Respondents who visit home regularly definitely scored higher than those who never return home, or rarely return home. This can indicate that these people may have more contact with a range of people and access to more information, at the same time they may also have greater access to risk situations, which is discussed in later sections.

In four of the five areas of knowledge there are strong correlations with correct responses and a moderate of good ability to speak Thai, and this was significant in three of those four areas.

Those respondents who had some prior knowledge or had gained some information of conditions on the border before migrating have higher scores than those who do not have prior information. The correlation is not strong, significance is demonstrated in only one of the five areas. However, as supportive data, there iss a strong association between those with prior information and respondents who have heard of STDs, thus those who receive some prior knowledge may be better prepared for staying in vulnerable and risky situations.

Those respondents who stated that their previous occupation was farming have the lowest rate of correct responses in four of the five areas of knowledge, and this is significant in the area of knowledge of transmission. The correlation is not strong but suggests that low education and perhaps limited contact with the outside world leads to limited HIV/AIDS awareness.

There are significant correlations with the period of time that migrants had been in the area. Generally this was between those who have only been in the area for 1-3 months and some or all other cohorts. The clearest message is that newcomers have less knowledge than others,

and this relates to the above variable on low awareness of people with limited general information.

The last three variables, 'prior information', 'previous occupation', and 'length of stay' may be explored further to determine how they can be used in programming. It is unlikely that pre-departure programs can be considered, however, it may be possible to design programs that identify newly incoming migrants. It can be taken into consideration that those who previously worked as farmers, who may be harder to reach than some other groups, may be particularly vulnerable.

Summary of overall knowledge through ANOVA

In addition to the analysis above one-way ANOVA was used to calculate overall knowledge according to occupation (Table 4.38). This involves collapsing the three general knowledge sections plus one section on transmission and one on prevention knowledge into one overall knowledge section. The mean knowledge score of all respondents is .5357 out of a score 1.0, which is substantially higher than that of Aranyaprathet which is .4489. This overall score may be misleading for while knowledge on transmission was very good misconceptions were high in Aranyaprathet, as is explained in the summary in 4.7. The category of others is the highest as this includes students and teachers, but the sample is small as well. Traders have the highest knowledge, among the occupational groups, followed by labourers, store employees, sugar cane workers and then workers in rice fields.

Table 3.31 ANOVA Compare Means of all Areas of Knowledge by occupation

Occupation	Number	Mean	Standard Deviation
Trader	61	.6118	.1827
Store employee	13	.5267	.1434
Labour	117	.5430	.1942
Rice field	98	.4779	.1910
Sugar cane	20	.4817	.2043
Others	9	.6593	.1405
Total	319	.5357	.1947

3.8 Attitudes and Beliefs on Sexual Behaviour

Masculine behaviours and acceptability

There were five questions referring to practices and beliefs that are associated with masculine prowess, and these have clear implications for the spread of HIV. The first question refers to what in Thailand is commonly known as *kheun khru* where young men may be initiated into sex through sexually experienced women such as sex workers. Other questions were dealing more specifically with myths or misconceptions, such as men displaying a belief in their invulnerability by not using condoms, thus non-condom use being associated with male bravado; and, men drinking alcohol as a stimulant to enhance sexual stamina and virility. Finally, two other practices are grouped together in one question as they are both designed to stimulate the female partner during sexual intercourse, the first is the use of marble implants incised into the foreskin of the penis, and the second is the use of oil injections into the penis for temporarily increasing the size.

Kheun khru has been a common practice in Thailand but reportedly has reduced in significance due to the AIDS epidemic. While it may not be a traditional practice in Cambodia it is reported that many young men have their first sexual experience with a sex worker (Tarr, 1997). The use of injections and implants has also been relatively common among some groups in Thailand but has apparently reduced in recent years. It still occurs in some fishing communities, and places where men live and work together. It has been documented among Thai and Burmese on the Myanmar border in recent years (see accompanying report on Myanmar border).

Table 3.32 Responses Agreeing to High Risk Transmission Practices by Gender

Practices and beliefs	Men	Women	Total
Kheun khru	44 (24.6)	19 (14.4)	63 (20.0)
Condoms and bravado	27 (15.0)	20 (15.3)	47 (15.1)
Implants and injections	29 (16.5)	7 (5.4)	36 (11.4)
Alcohol and virility	41 (22.7)	23 (17.6)	64 (20.5)

The relatively small proportions of people who agreed with these practices and beliefs disallowed any correlations of statistical significance, however, there are associations with the demographic variables of gender, marital status, and education. Men are more likely to agree than women, and married people are more likely to agree with these propositions than single people.

Respondents who agree with these practices and beliefs mostly have five years of schooling or less. As presented in Table 3.33 if the categories of no formal education and

1 – 5 years of education are combined over 60% of respondents in all questions agree with the propositions, and it is up to 73.9% for the question on male bravado being equated with not using condoms. It is notable however, that while most respondents who agree with these beliefs and practices were in the 1 – 5 year cohort, other respondents who agree exist across all educational levels.

TABLE 3.33 Responses Agreeing to High Risk Practices and Beliefs by Education

Practices and beliefs	Level of education				
	None	1-5 years	5-9 years	>9 years	Total
Kheun khru	27.4	41.9	21.0	9.7	100.0
Condoms and bravado	32.6	41.3	13.0	13.0	100.0
Implants and injections	20.0	45.7	28.6	5.7	100.0
Alcohol and virility	17.7	45.2	25.8	11.3	100.0

The proportions of respondents, 11% to 20%, who accept these practices are substantial. Exactly how to interpret this is not clear but it does suggest that these practices still exist in the community and may contribute to the spread of HIV in border areas. In the accompanying report on the Myanmar border some of the men interviewed currently had marble implants incised into their penis. Such practices clearly have implications for bacterial infections for them or their partners. These practices were not uncommon in Chiang Mai in the early 1990s. In 1992 one sex worker in Chiang Mai explained how she could not have sex for six weeks until lacerations from marble implants worn by a customer had healed (personal interview by the author).

The same proportion of women as men suggest that males can express courage, and perhaps a sense of invulnerability through not using condoms. This is of concern in trying to increase an awareness of condoms and increase their use. Over 20% of men believe that alcohol can increase virility, and it is reported in qualitative findings that many men are drunk when they have sex with sex workers, and many reports suggest that condom use is often inconsistent on such occasions (Pramualratana 1995; Beesey 1996).

Attitudes regarding normative sexual behaviour.

Attitudes to what is culturally and socially acceptable sexual behaviours are common across many cultures, and within much of Asia cultural norms, as expressed through a common denominator, do not vary greatly. Of course, within each culture there is a wide spectrum of behaviour not accounted for within common denominators or stereotypes. Each culture will vary from another even if classificatory systems and definitions suggest that there is a high degree of similarity. And attitudes will vary according to gender, age, education and other variables. Thus, it is important to have some understanding of the prevailing attitudes within a given community and this is what is explored here.

These questions evoked relatively predictable responses, with men generally agreeing more than women that pre-marital and extra-marital behaviour is normal and thereby acceptable. The statements, put as questions to respondents, refer to practices which are mostly perceived as taboos, or in contradiction to general community standards, but with varying degrees of censure. Thus, as expected, responses agreeing with the statements are in the minority, with 35.3% of all respondents suggesting that it is acceptable that single men visit sex workers; 35.1% saying it is acceptable for single men to have sexual relations with other women (not CSWs); and 16.1% responding that it is acceptable that single women have sexual relations with men. These responses reflect a fairly strong double standard, which can be found in most societies, allowing men a high degree of sexual freedom compared to women. This is affirmed in three more questions.

The other three questions evoked strong disagreement, or unacceptability of certain behaviours: married men having sex with sex workers, 94%; married men having sexual relations with other women, 88.3%; married women having sexual relations with men other than their spouse, 97.5%.

Table 3.34 Acceptability of Sexual Relationships

Sexual relationship	Agree	Not agree	Don't know	Total
single men with sex workers	35.3	61.2	3.5	100.0
single men with other women (not CSWs)	35.1	58.1	5.1	100.0
single women with men	16.1	81.1	2.8	100.0
Married men with sex workers	4.1	94.0	1.9	100.0
Married men with other women	9.2	88.3	2.5	100.0
Married women with men – not spouse	0.9	97.5	1.6	100.0

When testing for other variables there was little of significance and few relevant correlations could be made. Area 1 appeared to be more accepting of such behaviours and men were marginally more accepting than women.

In regard to education there are some correlations that need further exploration. There is a pattern that emerged in responses to five of the six questions. Those with no formal education and those with over nine years of schooling are less likely to agree with such behavior being acceptable compared to the two midway cohorts, 1- 5 and 6 – 9 years. In the sixth question respondents are almost unanimous in saying that it is not acceptable that married women have sexual relations with men other than their husbands.

Table 3.35 Acceptability of Sexual Relationships by Education

Level of education	None	1 – 5 years	6 – 9 years	> 9 years
Average % of respondents in agreement with all propositions	15.5%	33.9%	23.7%	16.9%

An hypothesis that might explain this pattern is that people with a higher education may tend to adopt conservative attitudes, or attitudes that conserve the status quo. As members of the middle classes they thereby adopt what is perceived to be acceptable national standards. Such standards may be an ideal rather than what occurs in practice and can become ethical/moral codes that are preached to lower classes. To explain why the cohort with no formal education had similar attitudes is more difficult and more speculative. It may be that they have adopted the consensus model of the government and middle classes more than those with some education, who may be more questioning. On the other hand it may be suggested that sexual norms or perceived standards of the educated are often less likely to influence the lower educated, who determine their own sexual standards, at least to some degree. However, this might be contradicted by conservative religious ideals which tend toward conservative sexuality.

Discussion and Summary

The women, and particularly the men, who agree with the ideas and practices referred to above as 'masculine behaviours', may belong to a hard core group of people who have practised very high risk behaviors. It can be very difficult to change such behaviour or correct misconceptions among this group. However, by providing accurate education that dispels such misunderstandings to the general community it is possible to gradually change risky practices. The men may have spent time as fishermen or as soldiers where they learnt these practices and beliefs. Such practices and beliefs may have made significant contributions to the rapid spread of HIV experienced in Northern Thailand where many people were infected in the 1980s before any preventive measures had been introduced. Other studies suggest that only a small subset of men who visit brothels practice high risk behaviours, such as not using condoms or some of the practices discussed here. This can allow for 'a disproportionate amount of risk' which may explain, in part, the persistence of relatively high HIV incidence among brothel sex workers (see CARE Cambodia, 1999).

The attitudes expressed in the responses to acceptable sexual norms demonstrate a fairly strong sexual double standard, where it is acceptable for single men to visit sex workers, and where it may even be encouraged. It is notable that a similar proportion that agreed with single men visiting sex workers agreed with single men having other sexual relations apart from commercial sex, and yet far fewer agreed with young women having sexual relations.

The small proportion, 4%, who find it acceptable for married men to visit sex workers may be accurate for Cambodia where the norms of some communities may be more sexually conservative. Brothels in Thailand seem to be more widespread in rural towns and across the countryside than in Cambodia, which may be a result of the severe dislocations and the lack of a disposable income in Cambodia. However, whether this is accurate or understated it has been shown in Thailand and in other countries that many women know that they have little power to curtail their husband's activities. In this situation women may not want to acknowledge that it is likely that their partner does sometimes visit brothels after eating and drinking with his friends. It should be noted here that these attitudes and behaviours can vary from one community to another. But also habits and customs can change in the new environment on the border, or across the border living in a different country.

Women need to be empowered rather than 'disempowered' which is more like what is happening given that women generally having less education and less understanding of HIV/AIDS. Increasing awareness and understanding among women will not change the power structures but it is the first step in developing a community awareness of how sexual codes of conduct that are normative in some societies allow for the spread of HIV.

In communities where males have privilege and power they may play a major role in dictating the norms or standards of society while at the same time breaking or bending certain norms. In Thailand men appear to be given a high degree of freedom to have illicit sexual relationships as long as these relationships do not otherwise interfere with the family and day to day activities. In these circumstances men may bend the rules even further and the outcome can be the rise of such practices discussed under masculine behaviours above. While the family may not openly discuss the advent of a boy being initiated into sex, as with *kheun khru,* they may know that it is happening and it can at least be privately understood and accepted, thereby giving it legitimation.

The next section discusses whether respondents see themselves at risk and this is followed up by actual risk behaviours. The following section discusses sex work and sexual networking from information mainly gained through qualitative research.

สถาบันวิทยบริการ
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3.9 Risk Situations and Sexual Behaviour

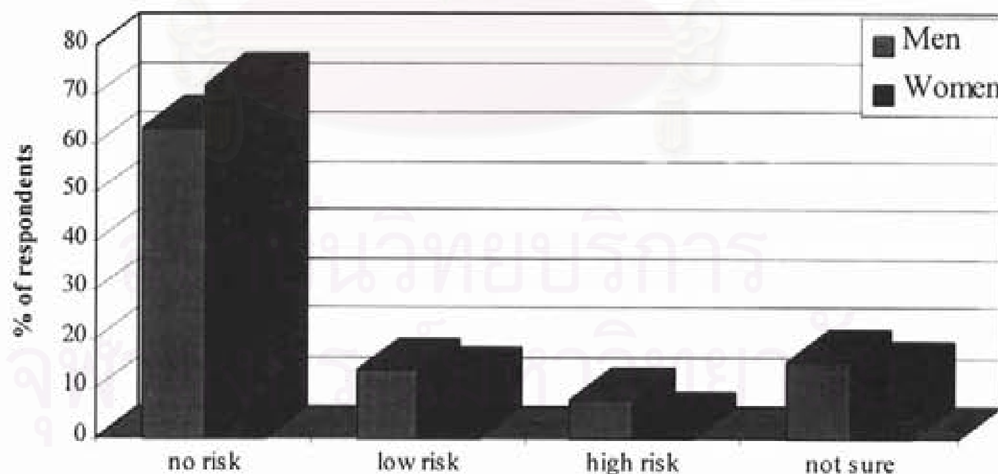
Self-assessment and reporting on risk behaviours

Most people did not see themselves at risk of infection, 67.3%, while 12.8% admit to low risk, with just 5.6% admitting to high risk, 14.3% are unsure. Of the 18 respondents who saw themselves at high risk, 14 are men, and the majority are married (see Figure 17). Almost 50% were labourers and the great majority are from Area 1.

Three percent of women felt that they are at high risk, compared to 7.7% of men; and 11.9% of women perceive themselves at low risk, compared to 13.7% of men, a total of 20 women with four saying high risk, and 39 men with 14 saying high risk. Given that there were no known sex workers in the survey these relatively high proportions may express the sexual vulnerability some women fear from some of the men they come into contact with. However, this is not clear as relatively few of them are from Areas 1 & 2 where key informants and other interviews said that women were open to abuse.

Overall the numbers acknowledging risk are low, which seems to suggest that many men are not aware of risk or deny that they put themselves at risk. For women it suggests that many are not aware, or do not acknowledge, that men can be infected through commercial sex or other sexual contacts and pass the infection on to them.

Figure 3.18 Self Assessment for Risk by Gender



On the question of **why they would think about prevention** 76% of the sample's first response is the fear of death. So even though most do not see themselves at risk a greater percentage know that AIDS cannot be cured, and thus this was in their mind. The second

choice was fear of transmitting HIV to their family, 11.5%, apparently through casual contact, which many feel is highly possible. The third was shame, 9.3%, and the last was just the fear of AIDS being close by, apparently meaning in the nearby neighbourhood or in the family.

On self-reported risk behaviours, 22.7% of the sample responded to the question of whether they used a condom with a partner other than their spouse in the last 12 months. Of the 73 respondents 25 admitted to 'never' using a condom, 20 stated 'sometimes', and 28 'always'. There was no correlation with education, and the main occupation groups were traders and labourers, with no occupation group dominant for any of the categories on frequency of use.

Of the 25 who never used condoms 13 are men and 12 are female. These 12 women are the total number of women who responded to this question. While it is a small sample, the fact that all the women who responded to this question never use condoms in extra-marital sex supports other studies which suggest that condoms are rarely used in non-commercial sexual relationships, assuming these women are not sex workers (Pramualratana 1995). The remaining respondents in this sample are all men, and 82% of them came from Area 1. Of these men 20 out of 48 are married, and the majority of married men use condoms, at least sometimes. There is little difference between condom use of married and single men (Table 3.36). We may assume, mainly from the fact that condoms are being used 'sometimes' or 'always', that most of these sexual episodes were commercial sex.

Table 3.36 Frequency of Condom Use with Non-spouse or Non-regular Partner by Marital Status

Frequency of condom use	Using condoms with person who is not spouse (or regular partner)							
	Married men %		Single men %		Married women		Single women	
Never	7	25.9	6	17.6	8	-	4*	100.0
Sometimes	7	25.9	13	38.2	-	-	-	-
Always	13	48.1	15	44.1	-	100.0	-	-
Total	27	100.0	34	100.0	8	100.0	4	100.0

* 3 of these 4 are widows

This question covers not only condom use with a person outside of their spouse but also is an admission of having had extra-marital sex, or sex outside of their usual couple. Thus, while there were 27 men admitting to extra-marital sex there were also 34 single men admitting to sexual relations outside their usual partner.

Other cross tabulations with migrant behaviour variables showed that 61% of the sample who admit to having had sexual relationships with someone other than their spouse are respondents who visit home regularly, compared to 39% who never or rarely visit their home town. The proportions of single and married men are equal. However, those who visit home regularly are likely to use condoms more consistently.

The majority of single men stay in families, however, proportionately, those living outside of the family who admitted to sex with someone other than their usual partner, were higher than those within the family, 51.5% compared to 31.5%.

Drug use

On the question of self-administering medicinal drugs through injection and sharing needles only 10 men, 3.1%, replied 'sometimes' and one 'always'. On ever having injected drugs of addiction only two men admitted to 'sometimes'. On ever receiving blood seven men, 2.2%, said 'sometimes' and one said 'always'.

Commercial sex work and sexual networking

Over the last five year period the numbers of sex workers in Poipet has increased and the number on the Thai side decreased. The major decrease in Aranyaprathet occurred five or six years ago after clamp downs in Thailand on under age prostitution, and Khmer sex workers appear to have been forced back across the border around this time. There are two restaurants that provide indirect sex workers and Arranyaprathet Public Health officials monitor these women. In addition, there are four karaoke bars and four massage centres that are likely to provide indirect sex work. In all premises the women appear to be mostly from Northern Thailand.

The HIV risk situation through patronage of commercial sex work on the Thai side, where most workers are indirect sex workers in restaurants or bars, would be minimal compared to the brothel and bar context of Poipet. Cambodian and Vietnamese sex workers who cross the border do not service migrant workers but officials, tourists, etc. However, most of these women come from brothels that migrants in Poipet patronise. Seasonal workers in Area 3 may have ready access to Cambodian sex workers on the farms in which they work. At the end of their seasonal work with money in their pockets some men may patronise brothels in Poipet as well. There is qualitative data from sex workers and other key informants that indicates high risk behaviours among some of the migrant groups. The study sample was not directly questioned on visiting sex workers in Poipet, or detailed questions on condom use, etc. (see explanation in Methodology); however, there were questions pertaining to attitudes and behaviour of the individual respondents and of community attitudes and norms in the section on HIV/AIDS.

In order to understand the risk environment for migrants it is necessary to have a full picture of the risk situation and the behaviour of other groups on the border. Each border situation is unique and this border is no different. With fewer sex workers on the Thai side the main risk environment for both Thais and Khmers is primarily from the sex industry in Poipet; however, within the big picture there are many tourists and officials on the Thai side who contribute to the spread of HIV in the general area.

The higher economic growth of recent decades in Thailand is a magnet for migrants seeking work in agriculture, construction, and other occupations including those working as traders. However, other mobile population groups include foreign and local tourists, police and border police, soldiers, government officials, truck drivers and others. Sexual services are provided through hotels and guest houses, mainly through sex workers being transported across the border. As the border area has expanded and more hotels and entertainment centres established the border area attracts more and more women as sex workers. For many years the military has had a large presence as well, and this adds to the demand for sex workers.

Uniformed men are often in a position to take favours from women sex workers and key informants could cite examples of them abusing their position of power in such a way. A range of different clients order women from Poipet at a price of B300. However, if the clients are uniformed men the women may have to service an unknown number. One former sex worker, who is now forced by border officials to act as an occasional agent, related a story of a sex worker having to service 20 such men. In such situations the sex workers do not bring sufficient condoms and some men may not care as they are usually drunk.

Informants also related how border officials provide girls from Poipet for visiting high officials for overnight stays in hotels in Aranyaprathet, and this appears to happen for officials or others staying in Sakaew municipality. Passing three check-points along the way to Sakaew does not appear to present any problems. Some military and/or police are not only implicated in facilitating the free passage of sex workers, but have been implicated in the trafficking of women (Phal 1997), at least on the Cambodian side, and high ranking personnel may own and operate brothels (one such person was key informant).

Some wealthy older locals have connections with brothels who contact them when they have virgins. This situation does not appear to have changed much over the past five years, as it was explained in the Mahidol report, one brothel had at any given time had a virgin, or recent virgin (possible meaning up to 10 sexual episodes) to attract customers (Pramualratana 1995). As reported elsewhere, condoms are rarely used on these occasions. One sex worker interviewed related a story of how she was told by her boss that she must not use condoms on these occasions. When the client insisted on using a condom she broke down and cried as by using a condom she was going against the wishes of her boss. This is a very high risk activity which clearly puts the young girl at risk and not so much the client. Some research has shown that most sex workers in Thailand were infected in the first six months of working, and it may well be that many are infected in their first sexual episodes.

According to informants young women, especially more attractive women, crossing to work on farms in Area 2 may be vulnerable to sexual abuse including rape by uniformed officials. In such situations the district health officer suggested that these men do not use condoms because they view these women as free of disease. Even in Area 3 where many

people are married and in families there are some single women who according to a village health volunteer are vulnerable to sexual abuse or rape. A woman who once worked in sugar can plantation confirmed such stories, adding that after seeing her friend raped she asked a man to sleep near her, and then paid him to do this on subsequent nights so that she would be safe. They developed a close relationship and eventually married. It was also claimed that it is not uncommon in some communities for Cambodian women to marry at a young age in order to protect themselves from abuse.

In addition, girls or women in this area sell themselves to Cambodian workers, this often occurs on pay day. Girls working in one area with a group of workers may visit groups of workers in adjoining fields for this purpose. Local Thai men are also customers and it was stated that they are usually quite drunk.

Sex workers in Aranyaprathet and Poipet

Cambodian sex workers come from many different provinces. It is suggested that many Cambodian girls or women are trafficked, or at least tricked into sex work. Vietnamese women are more likely to be voluntarily working in Poipet and travelled by themselves or with a parent which is fairly common according to one informant. This was the situation in the two case studies of Vietnamese sex workers below. The numbers of Cambodian women being trafficked may have reduced over the years, due in part to the market for young foreign sex workers reducing in Thailand, which in turn is a result of the AIDS epidemic affecting brothel attendance and also to government campaigns against child prostitution. Thus, less trafficking across the border may have an impact on tafficking to border locations. One Cambodian sex worker said that she initially worked in the local market, then after meeting a man and living with him but then separating, she moved into sex work. She suggests that this is a common route for Cambodian women in becoming a sex worker.

Cambodian sex workers suggested that most of their customers were Thai. Condoms are supplied free in the brothel, said one woman, but another said that they cannot bargain with customers who do not want to use condoms. They admitted to being afraid of their owners as well as police and border officials. One woman said she will shower after sex and douche her vagina with a lotion but she did not know what the lotion was.

A Thai sex worker from Chiang Rai worked in Aranyaprathet over 10 years ago. She returned home to marry and after 12 years of marriage her husband died, so she made plans to return and has only been here a relatively short time. In that time however, she claims to be having regular customer who are soldiers, but also has other customers who include police officials, traders and wealthy Cambodians, she likes Khmer clients and doesn't like impolite Thai soldiers. She will refuse any customers who do not use condoms but admitted there may be occasions when condoms are not used.

Case Studies: Two Vietnamese Sex workers

 # 1 Paka

Paka (not her real name), is part Vietnamese and part Cambodian from the Vietnamese border area. Typically, it seems, she comes from a poor background, is an elder sister, and has a failed marriage where her husband beat her. Her mother helped her to leave her husband and they went to visit an aunt in Poipet. They couldn't find her aunt and ran out of money and the mother suggested that she sell her body one time only. But the woman said that if she couldn't go back to her husband she could stay and work here in sex work. The mother agreed and said she would tell her father that she was staying in Poipet for 6 months with her aunt. For her first episode she was paid B3,000 by a Thai client who did not use a condom. She borrowed another B3,000 from the brothel owner to give to her mother.

Paka has received AIDS information from a foreign doctor, probably MSF. She explains that Cambodian customers pay B100 while Thai pay B300, she prefers Thai clients even though she cannot speak Thai. Thais use condoms more than Khmer clients and she adds that they are more polite and kind.

She claims that the brothel owner sometimes beats them and that two workers have died from beatings. She plans to stay for the six months and to have earned enough money to start a small business. She hopes that nobody in her village will know of the work she has been doing because she will have only been away for six months and no-one will be suspicious.

 # 2 Kaeow

Kaeow, was born on the Vietnamese border moving to Phnom Penh at the age of 13. Her father left the family for his minor wife. Her mother already had four children and fell pregnant with another. Kaeow estimated that more than 20 girls from her village have gone to work in Poipet. Eight months ago she made a decision to come to work in Poipet and asked her mother to take her there. She received a loan of B30,000 to give to her mother to build a new house. Her first experience (*pert sing*) was a local Thai-Chinese over 60 years old, no condom was used and she received B7,000. In her brothel there are 23 sex workers and at least half are Vietnamese and the remainder are mixed Vietnamese and Cambodian ethnicity. They have cooks, laundry

workers and maids in the brothel. Thais pay B100-200 in Poipet but there are not so many customers during the day. It costs B300 for customers who order women from across the border, but this price may include several men especially soldiers or police. The Vietnamese are more expensive than the Cambodian girls who may only charge locals B30-40 for Cambodian clients. Kaeow speaks some Thai and most of her customers are Thai. They are more likely to use condoms, and they give tips, so she prefers them. Although she does not like Thai police who are mostly drunk and she has to service several of them one after the other. Thais are a bit strange she feels in wanting to try different positions, but Khmers are more aggressive, especially soldiers who make many demands. She has four or five Thai men as regulars and some want to marry her, they are mainly soldiers. She doesn't like them and has a Cambodian boyfriend, who is the son of a High ranking soldier. The father recently posted him elsewhere in order to separate the two of them as he does not approve.

The foreign doctor from MSF has visited and provided information, including how to bargain for condom use, and the owner has followed up with the same messages. She thinks a sex worker died from AIDS and is under the impression that many other people in Poipet have died. She has had vaginal discharges or an infection, it is not clear, and received medicine from the owner, in addition she was taken to the doctor for an injection. She wants to return home soon and if she can she feels that nobody will suspect what she has been doing. If she had her time over again she said she would not work here. Her mother wanted the second eldest to work in the brothel also but Kaeow was adamant that she should not.

Case Study, #3:
Nin – abused, cheated, jailed and now an agent!

Nin, a Cambodian migrant, was working in the sugar cane fields with her friend when her friend was attacked and raped by another worker. To protect herself, Nin paid another fellow worker, a Thai man, to sleep by her side so that she would not be attacked. She became friendly with this man and they later married, in 1992 when she was 18 years old. She moved into his family home, very close to the border but still in Thailand. It seems that because she was Cambodian her father-in-law looked down on her and forced her to sleep outside the main house, and sometimes he beat her.

An acquaintance who knew of her plight told her he could find her work in another province if she wanted to run away, and she accepted his offer. He took her into Aranyaprathet township and put her into tour van with dark tinted windows. She found herself in Ladprao Bangkok that evening, and the following morning was transported to Pajuap Khirikhan in the south. She realised this was a brothel and claims to have been injected with drugs that made her compliant, and able to serve clients.

After two months she was able to escape with the help of a foreign (westerner) client. She ran into a banana plantation and hid for three day without food, for she was sure that they would be out looking for her. Finally, she walked to the highway and hailed down a bus and asked the driver if she could go to Bangkok adding that she had no money. He allowed her on and she arrived in Bangkok the next morning.

In Bangkok she followed a monk, returning from his alms round, to his temple and asked if she could stay. He allowed her to stay and do some cleaning to pay her way; however, he also offered her money for sexual favours. She left the temple shortly and found work on a construction site and after earning B2,000 returned to Aranyaprathet. She took up living with her Thai husband and things improved a little as his father had died so she could stay in the main house; however, a sister-in-law was still living in the and took every opportunity to abuse her, encouraging her brother, Nin's husband, to beat her up.

She found regular work in the village, such as washing clothes or cleaning, or sometimes working in the fields. Her husband, however, rarely worked, only occasionally working in the rice field. He was drinking three cans of Grating Daeng, a commonly available drink high in caffeine, which she was compelled to purchase for him daily, even when it put her in debt.

Nin and her husband have been jailed twice, her for being an illegal immigrant and him for harbouring her. On one occasion they were jailed for one month. During 1995, border officials approached her to get some sex workers for them, from Poipet. She couldn't refuse them so she did so and now has joined many others on the border who act as agents for bringing sex workers across the border. Nin is given B300 to go to the brothel to purchase the girl, which she does on her bicycle; B150 goes to the brothel and B150 to the sex worker. As with other agents, Nin is not assured of getting payment, the client will usually tip her but after delivering the girl she has little power to negotiate, especially with officials. She has to return the girl the next morning, as they must always be accompanied when crossing the border. However,

there was a time when one girl escaped and the brothel acccused Nin of helping in the escape. Ever since this happened Nin has had to carefully avoid this brothel.

Nin says that her husband forces himself on her everyday, and in addition sometimes makes her bring a sex worker back for him. He never uses a condom when having sex with Nin, she gets injectable contraceptives from the health station. She has also had sex with other men. One time she left her husband, after he had beaten her, and went and worked in the rice fields where she met a man from Northeast Thailand. He gave her B2,000 and they planned to marry, but then she saw him get very drunk one night and changed her mind. Recently she met a rich Thai man but then found out that he is married, so she is uncertain what to do.

There is no suggestion that Nin is infected but she has been exposed to commercial sex as well as having sex with a number of men who have had unprotected sex with her. This is only one example the forms of sexual relations and sexual networking that occur.

Nin came from a broken family and has no contact with her father at all. She does not want to return home to her mother as she has no money. Only on one occasion did her mother come to visit and Nin could only give her B100. She has no plans for the future.

Discussion and Summary

In Poipet, local men as well as Thais and other foreigners, patronise the several hundred sex workers every day. Both married and single men visit sex workers, and given that their knowledge of HIV/AIDS is limited, and that misconceptions and myths still prevail is of great concern. Single men are probably more regular brothel patrons, and it was a positive finding that they had better knowledge than married men in almost every area of knowledge tested. However, young, single men were far less likely to have heard of STDs than older, married men, which suggests that they may not be prepared to protect themselves from STDs. STDs are currently a major problem in Poipet, a problem that has drastically reduced in Thailand, including just across the border in Aranyaprathet. The qualitative findings, as well as secondary sources, suggest that Thai men are more likely to use condoms than Cambodian men, and Vietnamese sex workers are more likely to use condoms than Cambodian sex workers. This leaves low or inconsistent use of condoms between Cambodian sex workers and their Cambodian clients and allows for possible STD or HIV infections.

Most respondents 60.7%, did not see themselves at risk; however, this leaves a substantial proportion who saw some risk or were not sure. And in fact 22.7%, or 73 respondents, admitted to having sex with someone other than their spouse in the last 12 months, and it is likely that this is under-reported. The fact that these respondents did not use condoms, or did not use them consistently, is probably accurate and is cause for concern, especially as it is likely that most of those sexual contacts were with sex workers. Twelve of the 73 respondents were women (8 married, 3 divorced, 1 single), and they never used condoms, which is consistent with many reports of low condom usage outside of commercial sex.

The study sample for this research represents a good proportion of Cambodian migrants, and migrants make up a large proportion of Poipet township and its surroundings. The overall findings of HIV prevalence, the prevailing risky sexual practices, and limited HIV/AIDS awareness, suggests a high vulnerability for migrants. For most migrants, who live in Poipet or nearby and commute to Thailand daily, the risk context is their home town, Poipet, but for others, such as revealed in qualitative and quantitative findings in Area 3, it may be extremely risky for seasonal workers within Thailand.

The high risk situation for HIV in Poipet is a result of its context as a border area where besides legitimate trading smuggling is common, and along with other underground activities, the area can attract many people seeking to exploit such opportunities. Originally many sex workers were working from brothels in Aranyaprathet but now this is rare, though they still exist by night, transported over from Poipet. Migrants are only one element in this milieu of mobile and migratory populations who may contribute to, and are affected by, the spread of HIV. The evolution of this high risk context and the continuing risk situation can be attributed to other mobile population groups and not the migrants themselves.

It may be predominantly Thais or foreigners who have unprotected sex with virgins, which is perhaps the most vulnerable time for young women to be infected. And it is often Thai uniformed men who have multiple sex with a sex worker transported from Cambodia. On the Cambodian side exploitation is likely to occur also where within the ranks of police and military there is an extremely high prevalence of HIV infection (see Part 1). Once infected sex workers pass on the infection through unprotected sex, and as just stated this is more likely to happen with Cambodian men, mostly migrants, who are least prepared, that is, they have limited knowledge, and for this and other reasons, they may be less motivated to have protected sex.

Women are obviously vulnerable to sexual exploitation and possible infection. The overall findings on knowledge and general awareness for the total sample is relatively low, but women had even lower awareness, which is one factor that can make them more vulnerable, even if they are not actively pursuing sex or sexual relationships in the same way many men are. They are vulnerable as workers, as stated in the qualitative findings, in Area 2 and Area 3, due to direct sexual abuse including rape. In Area 2 this was by

border officials, and in Area 3 by other workers. They are vulnerable to entering the sex trade through force or through economic need. They are also vulnerable to infection through sexual relations with their spouse or regular partner who refuses to use condoms.

Sexual networking was not explored in any real depth in the quantitative survey, partly due to difficulties with a planned self-administered questionnaire. Limited data was gathered from qualitative research; however, both forced, consensual and commercial sexual relationships were reported in all Areas, sometimes all three could be said to have an overlapping relationship. In order to avoid being raped by amorous men in the vicinity, one woman asked a man to protect her, which in turn became a consensual relationship. A former sex worker turned agent brings a sex worker to her house for her husband to have consensual, non-commercial sex! All three were reported for Area 3.

It is likely in this climate of social and economic hardship, where adapting to changing economic fortunes is necessary for survival, that beyond commercial sex there is quite extensive sexual networking. In this study there is a relatively high proportion of widows which reflects the situation in Cambodia due to the Khmer Rouge regime and ongoing conflicts. It is well documented in Thailand and in the region that widows, female traders and other women may form relationships with men for financial support, and many of these men belong to mobile groups such as truck drivers, police, border officials, and traders (Pramualratana 1995; Beesey 1998).

3.10 Attitudes to People with HIV/AIDS

From the above findings on casual transmission of HIV it was clear that fear was uppermost in the minds of many people. Respondents clearly categorised AIDS as a communicable disease and therefore easy to catch. Fear appears to be behind the responses to living with people with HIV/AIDS.

The majority of people, 51.3%, correctly, disagreed with the statement that HIV is not easily communicated to others and thus people should not be stigmatised or avoided; however, 44% agreed with the statement. Most people felt sympathy for PWHAs, 62.8%, but 35.6% did not. These proportions were reversed however, when interviewees were asked whether they could be friends with a PLWA, with 60.6% saying they could not and 35.9% saying they could.

Approximately equal numbers of respondents said that they would visit a friend who had HIV/AIDS, which means almost half of the respondents would not visit their friend, 48.6%. Consistent with the above, 72.4% suggested that PWHAs should be isolated with special care, and 68.6% said that if a member of the family had HIV they could not stay in the house.

If a member of the family had AIDS most people, 76.7%, would take them to the doctor, others would seek special medicine, 9.3%, or to the temple for special care, 4.3%. Don't know or unsure responses for all questions were low, between 1.6% and 4.7%.

Table 3.37 Attitudes Towards People with HIV/AIDS

Attitudes toward PWHA	Agree %	Not agree	Don't know	Total %
HIV not easily transmitted, should not be afraid	51.3	44.0	4.7	100.0
Should have compassion and pity for HIV/AIDS person	62.8	35.6	1.6	100.0
Working with or being close friend with PWHA	35.9	60.6	3.5	100.0
Visiting close friend who is PWHA	48.6	49.8	1.6	100.0
PWHA should be isolated with special care	72.4	24.4	3.2	100.0
Allow family member who is PWHA to stay at home	28.8	68.6	2.6	100.0

Each of the six questions was given a score of +1 or -1, according to correct or incorrect responses, and 0 for don't know/not sure responses, then the means score was determined and compared using Anova.

Of the total sample, 56% of respondents were in the negative, and only 29% in the positive, that is, having responded correctly for most of the questions. Correct responses suggest that the respondent was aware that casual contact with PLWAs was not risky and thus were more accepting. The remainder were neutral, mostly having not sure/don't know responses.

Males had significantly higher rates of positive or correct responses than females. Single people had more positive responses than married people. Widows (n=15) actually scored the highest. There was a significant difference in those with no formal education having lower scores than those with 6-9 years and those with over 9 years.

Traders had significantly higher rates of positive responses than labourers and agriculturalists, which is consistent with Area1 having significantly higher rates than Area 2 and Area 3.

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Multivariate Analysis

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

HIV/AIDS Knowledge

Knowledge, as the dependent variable, includes general knowledge of HIV/AIDS as well as knowledge on transmission and prevention (see 3.7). These three areas of knowledge were combined to form overall knowledge for this analysis. The predictors are selected from 16 demographic and migration variables which are all tested against knowledge as the dependent variable. They are selected according to the theoretical conceptual model, presented in Chapter 2, and the study findings (3.7).

Demographic variables were: age, gender, education, marital status, occupation. Migration variables were: hometown, previous occupation, encouragement for migrating, prior information before migrating, relative in hometown, contact with hometown, frequency of visiting hometown, income, savings, sending remittances, length of stay, place of living, living with whom, community participation, recreation activities, Thai language skills. Another variable was self-assessment for risk of contracting HIV (3.9).

Table 3.38 Multivariate Multiple Regression of Demographic and Migration Factors and Attitudes on HIV/AIDS Knowledge

Predictors	β)	t	Sig.
1. Education – higher	.304	3.026	.00
2. Gender –male	.254	2.669	.01
3. Hometown			
- Bantambang	-.205	-2.381	.02
4 Hometown		-	
- Kampong Cham	-.181	2.063	.04
5. Marital status			
- divorced	.172	2.132	.04
6. Marital status			
- widow	.166	2.080	.04

R^2=.473 F=2.355 Sig.=.00

As shown in Table 3.38, the predictive variables for knowledge are as follows: Demographic: education, gender, and marital status.Migration: hometown.
There are six significant variables, four are positive and two are negative correlations with the dependent variable. Higher education has positive correlations with knowledge

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and men are more likely than women to have good knowledge. Those from Battambang are likely to have less knowledge as are those from Kampong Cham. Widows and divorcees, who are mainly women, are more likely to have good knowledge.

Risk behaviour

Risk behaviour, defined here as multiple partner sex (with casual partners or sex workers) is the dependent variable. The predictors are selected from the demographic and migration variables, described above, plus attitudes on two areas, namely: attitudes toward social norms, and attitudes toward PWHAs, 3.8 and 3.10 respectively. In addition, other variables are the overall knowledge score and self-assessment of risk, 3.7 and 3.9 respectively.

Table 3.39 Multiple Regression of Demographic and Migration Factors and Attitudes on HIV Risk (multiple partner sex)

Predictors	B	S.E.	R	Sig
1. Income – higher income	- 2.1166	1.0305	- .0840	.00
2. Living with whom				
– same sex friend	.0003	.0001	.1600	.00

Predicted percent correct = 77.62   Chi-square = 42.023   Sig.= .00

In Table 3.39 there are two significant migration variables, one is negative, namely high income is associated with multiple partner sex. The second is a positive correlation, that is, those living with same-sex friends (mostly all male households) have a high probability for having multiple partner sex.

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3.11 Health and HIV/AIDS Prevention

Migrant Health Seeking Behavior

Few Khmer people receive treatment from the hospitals in Aranyaprathet. This is far different from the Myanmar border where although hospitals have little or no budget for migrants many are treated nonetheless, and the hospital is often the first choice of Burmese who are seeking medical treatment for a range of ailments. The situation in Trat is more like the Myanmar border (see Chapter 4). The difference in Aranyaprathet appears to be that not many Khmers are freely allowed to stay on the Thai side of the border, apart from being daily commuters. There are no Cambodian settlements across the border and thus no community as such. This situation does not lend itself to migrants feeling they are free to seek treatment.

The hospital has treated very few migrant workers over the years, and while there was an increase of migrants seeking treatment in 1998, it is not clear how many were actually migrant workers, as key informants suggested that more wealthier migrants are now crossing the border seeking higher quality health care. The hospital will accept migrant workers in emergency situations; however, under normal conditions few migrant workers appear to access health services at the hospital. Knowing that some costs will be incurred it is perhaps a deterrent for many.

Many people near the border, however, can cross and seek services from the Thai health stations. Costs are incurred but they are minimal, and some may receive free treatment for minor illnesses (data on health care facilities is discussed in Health Services, Part 1).

From the questionnaire it was found that 12.7% (n=41) had ever been to a Thai hospital. However, when asked where they would go if sick, 17.1% responded that they would go to a Thai hospital. Most respondents, 59.6%, said that they would go to a Cambodian hospital.

Of 60 women who had given birth during the period of their stay in the border region, only one had the baby in a Thai hospital, 20 gave birth in a Cambodian hospital and 32 with the assistance of a mid-wife. One gave birth herself in Thailand, one in Cambodia, one in a Thai health station, and one with a Thai birth attendant. Of 92 respondents who had children under one year old 55 (59.8%) had received vaccinations. Many did not know what vaccine it was and it was unclear whether they received multiple vaccinations.

Of those who responded to the question on whether they, or a member of their family, had ever been very sick, 15 said that they had had tuberculosis, one was associated with HIV infection; 7 had malaria, 3 drug problems, 3 had syphilis, 3 psychological problems, and 2 had AIDS.

Given that few people attend the hospital and there are minimal costs at health stations, most respondents, 90.4%, did not have problems utilising medical services in Thailand. However, 7% did cite costs as problematic, and 8.4% cited language problems; smaller percentages cited rejection from hospital, 3.2% (n=10), and poor practices of staff, 1.2% (n=4).

Health Services and Prevention of STD/HIV/AIDS.

There appear to be a number of obstacles to migrants receiving treatment, general health information, and HIV/AIDS information from health services in Thailand. This is partly to do with the particular circumstances of this border area where the migrant workers are either daily commuters or living in relatively isolated farming areas. It may be that under such circumstances health services can avoid their obligations to migrants, which are mainly to provide basic services as part of their program of reducing the likelihood of communicable diseases crossing the border into Thailand.

Health service providers in Poipet are mainly private Cambodian clinics, in addition there is the MSF STD centre. There are many pharmacies also, however, as with some of the clinics people in attendance are often unqualified people. The existence of resistant strains of STDs suggests that medical treatment is inadequate, and this seems to be true for treatment of other health problems. STDs are still prevalent in Poipet while having reduced significantly in Aranyaprathet. This suggests that HIV/AIDS information should definitely include information on STDs.

The disparity in health care between the two sites is great, and instead of the Thai side assisting in the basic infrastructure and treament on the Cambodian side Poipet is left with inadequate services. Now it seems that more people are crossing the border, if they can afford it, and seeking treatment in Aranyaprathet. However, for most of the population on the Poipet site they are left with limited services and little in the way of information that can help prevent disease. This situation may be increasingly disadvantageous to Thailand as they may find it more difficult to control communicable diseases in the area if they escalate.

MSF is focusing on STDs but also does outreach that includes information on HIV/AIDS. There appears to be limited programming apart from this in an area where the prevalence of HIV is high and the potential for spreading more rapidly is certainly there given the size of the sex industry, other risk factors, and the generally limited understanding of HIV/AIDS by migrant workers.

3.12 Conclusion and Recommendations

Final Summary, Discussion, and Recommendations

Aranyaprathet is the main border crossing between Thailand and Cambodia. Although much of the mobility is more localised it is the main route from Bangkok to Phnom Penh. It is a major market area with extensive trading which brings many traders and business people to the area. Poipet is the cross-border area in Cambodia which has become a bustling city in the district of Srisopon, Banteay Meanjey Province. The area has been the site of many military conflicts which have only recently declined, allowing the border to be opened much more consistently than four or five years ago. In the border region of Poipet many people have travelled from adjoining provinces, or more distant provinces, seeking the opportunities that economic activity on the border provides. Substantial numbers of these are some of the tens of thousands of recently resettled refugees, and others may be refugees who were resettled in areas near the border region.

For this study migrant workers were selected from six occupational groups. Agricultural work is the most common occupation followed by farm labourers and construction labourers, then traders and retailers. The total sample was 318 respondents, 183 men 135 women. Most were daily commuters, returning to Poipet each evening. The core instrument in the research was a structured questionnaire, administered by locally trained bilingual researchers with the support of ARCM staff. Qualitative research through interviews with key informants and in-depth interviews with target group members was used for background material and to supplement quantitative data.

Summary of findings

Migration behaviour and conditions on the border

1. The majority of workers in Aranyaprathet are daily commuters, returning to Poipet each afternoon. They either cross at the main immigration check-point (over 2,000 each day), or at several other designated areas along the border, which are specifically for workers (up to 2,000 each day, depending on seasonal work available).

2. In Area 1, the main check point and a busy market area the main occupations are traders, retailers, service industry workers, porters and labourers. In Area 2, the designated areas along the border migrants are working on farms or labouring work.

3. The third grouping, in Area 3, are seasonal workers on farms who live in relatively isolated areas for the duration of the work period (up to 1,000 but many more in other areas, especially adjoining districts).

4. The majority of respondents come from Bantery Meanchey, 40%. Most others come from Battambang, Siem Reap, and Kampong Cham – half of the respondents were farmers before leaving for the Thailand.

5. Agents were not generally used by migrants to find work, almost all respondents came on their own initiative with information or support from friends.

6. The majority of workers live in families and many work as couples or in family groups. They have migrated together or followed the first member of the family who migrated.

7. There is a relatively large population of never married men but most are living with families. Thus, few people are supporting families at home (the picture may be different for sex workers and other migrant workers in Poipet).

8. Over half the sample have no, or little, contact with their hometown, thus, 65% never send money, and over half of those who do send money send less than B1,000 annually.

9. Small remittances corresponds with low incomes – almost 80% earn below B2,000.

10. About 40% of the sample visit home regularly (at least once or twice per year): People who regularly visit their hometown are more likely to have more HIV/AIDS knowledge and awareness, but also increased opportunities for more sexual contacts, however, such respondents have protected sex more than others.

11. Almost 30% have been in the area over two years and more than half of these over four years, but at the same time over 35% have been in the border area three months or less:
Newcomers to the area are vulnerable as they generally have lower HIV/AIDS knowledge than others. Other factors that can add to their vulnerability include having no Thai language at all, having no prior information before coming to the area, and being farmers in their prior occupation.

HIV risk situation

12. The border crossing is a major centre of business and trade, attracting not only migrants but many others, including truckers, tourists and business people. As the main thoroughfare from Phnom Penh to Bangkok it is also a route for trafficking and smuggling goods.

13. Trafficking of women was common in the past, and for some years there has been a big demand for sex workers from the different mobile population groups as well as the large military presence. Other uniformed men are regular customers of Poipet sex workers.

14. Migrants from elsewhere in Cambodia are also employed in the relatively large precincts of Poipet. The construction of a large casino complex has employed many migrants and attracts many Thais and foreigners.

15. Commercial sex has reduced in Aranyaprathet with most of it being indirect sex work with Thai women. No Cambodian or Vietnamese sex workers were found to based in Aranyaprathet township.

16. The high risk situation for migrants is in Poipet, where there is a high prevalence of HIV, relatively high prevalence of STDs, and a big commercial sex industry. The same sex workers often service migrants as well as Thais and foreigners; the latter are serviced either directly in brothels on the Poipet side or through being transported to hotels and guest houses in Aranyaprathet.

17. Commercial sex and other sexual contacts, including sexual violence is known to occur on the farms further inland in Aranyaprathet where there are many seasonal workers.

18. Condom use is highly inconsistent in commercial sex work, and both single and married male migrants are known to engage in sex outside of their regular partner. The most inconsistent use is among Cambodian sex workers, rather than Vietnamese, and among Cambodian men rather than Thai men.

19. There is evidence of sexual networking outside of commercial sex as well as the links between commercial and non commercial sex, with condom use in the latter being very low.

HIV/AIDS: awareness - attitudes - misconceptions

20. Awareness and understanding of HIV/AIDS is inadequate with many misconceptions on prevention as well as on some practices and beliefs that are potentially high risk behaviours.

21. Misconceptions on transmission of HIV, namely that HIV can be transmitted through casual contact, corresponds with a high degree of fear toward PWHA.

22. Women have low education, low income, and low HIV/AIDS knowledge, which can make them vulnerable to HIV infection, and they are vulnerable to sexual exploitation.

23. Low income and low education is associated with inadequate understanding of HIV/AIDS transmission and spread; and low education is associated with certain beliefs and attitudes that potentially lead to high risk behaviours; however, such attitudes can be found across all income and educational levels.

Health and HIV/AIDS services

24. Most migrant workers seek health care services on the Cambodian side of the border. Government services are very limited and pharmacies and private clinics often have unqualified people in attendance, otherwise cost is a barrier to adequate services.

25. MSF is currently providing a clinical service for STDs and reportedly has many people seeking treatment. They also undertake outreach work on HIV/AIDS.

26. In 1998 there were several hundred visits to Thai health care services by migrants, however, most attended at health stations for minor complaints rather than the hospital. This is a relatively small number, however, the number maybe increasing, in which case limited Thai language ability may be disadvantageous for gaining reliable health information and adequate treatment.

Summary of factors determining knowledge and risk of HIV for migrant workers: findings from multivariate analysis

1 From multiple regression analysis the main factors for knowledge of HIV/AIDS are prioritised in the following sequence:

Variable	Factor	Level of knowledge
Education	higher education	Higher knowledge
Gender	Men	Higher knowledge
Place of origin	From Battambang	Lower knowledge
	From Kampong Cham	Lower knowledge
Marital status	Divorced	Higher knowledge
	Widowed	Higher knowledge

2 Factors determining *risk through having sexual relationships with someone other than their regular partner, are prioritised in the following sequence:

Income	High income	Higher risk
Living with whom	Friends in all male household	Higher risk

*Risk here is multiple partner sex, so it is not necessarily high risk as in unprotected sex, although condom use was relatively low in most sexual contacts. The variables tested against low frequency of condom use showed no correlations.

Discussion and Concluding Remarks

The general understanding of HIV/AIDS is very basic and there are many misconceptions among large sections of the migrant population surveyed. The knowledge and general awareness was particularly low among women. Risk factors for sexual transmission are relatively high, especially among men but sexual exploitation places both men and women at risk. Vulnerability arises from limited understanding of HIV spread but also from high risk behaviours among groups that may be well informed but have greater opportunities for sexual outlets. Thus, gender issues figures prominently in the concluding remarks, going beyond knowledge and awareness as factors in behaviour change and vulnerability. Marital status and the rating of risk for single people is discussed in relation to their living situation, and broader issues of condom use and the risk situation on the border.

Migration behaviour and background factors for vulnerability

Aranyaprathet is a major centre for trade and business between Thailand and Cambodia. It also has an international flavour with major market areas selling products from other Asian countries, plus foreign businessmen, tourists, and casino patrons among the many Thais and some wealthy Cambodian countries. For many migrants it has been their transit point on their way to work in Bangkok or other areas. This flow of migrant workers has slowed due to the economic crisis; however, the flow of migrants to work in the border area has been less affected by the crisis (Sophal & Sovannarith 1999), even though contruction work and some other businesses were badly affected (see introduction).

Migrants mostly live in Poipet, some in the township area, others in village areas outside. They commute daily into Thailand either through the main immigration check-point or through other special check-points where they are met by Thai employers, who through the border official sign in the workers for the day and transport them mainly to rice fields or other farms. These are often couples or family groups who have crossed from the villages in the vicinity of Poipet. Some work as labourers in construction or labouring work on farms.

Another group is seasonal workers who work on farms, many of these people are couples of family groups as well. They may bring dried foods and condiments with them for the duration of their stay. The area is quite isolated being approximately 15 kilometres from the border and some distance from the town of Aranyaprathet.

There are significant findings showing that the longer migrants are working in the border area the more knowledge they have of HIV/AIDS. In terms of length of stay the clearest message was that newcomers have less knowledge than others. Having limited knowledge and understanding of the general risk situation in the area clearly disadvantages migrants. Even though family groups predominate qualitative findings

suggest that men usually come to the area first and then families follow. Thus it is possible that men could be infected with HIV before their families arrive.

Migrants who had general prior information from friends or others before coming to the border area appear to have gained more knowledge on HIV/AIDS as well, and in addition much higher proportions of these respondents have heard of STDs. More qualitative research is needed to see the types of information people receive and how this influences their behaviour.

With this data on new arrivals to the area, and those having some prior information being generally better informed, it may be possible to explore strategies that lead to developing programming that could reduce vulnerability. In this regard it should be noted that those who stated that their previous occupation as farming are the most likely to have poor knowledge of HIV/AIDS. Farmers may be the least informed on the outside world and have the least knowledge on HIV, and thus if they can be identified may be targeted for HIV/AIDS education.

Low literacy in Thai can make migrants more vulnerable as well. It may prohibit them accessing health care and gaining information, and it may be disadvantageous in working under Thai bosses and having to deal with Thai officials. Over 20% have moderate or good skills in Thai language and these respondents have higher knowledge of HIV/AIDS. The remaining 80% of respondents do not have skills in Thai language, and many have low literacy in their own language. As daily commuters most do not seek health care or health information in Thailand, and few socialise or seek entertainment or commercial sex in Thailand. However, some commuters, as well as those doing seasonal work on farms, may be disadvantaged by having few or no Thai language skills. It is notable that when asked if they wanted to do further study and if Thai language would be a priority, 80% expressed an interest in studying Thai language.

Health services and access

Health services are usually open to migrants in border areas, albeit with sometimes only basic services and minimal attention from staff. The hospital in Aranyaprathet however, does not treat many migrant workers, more are treated by health stations near the border, but only for minor ailments. In total, there may be only several hundred visits to the hospital (often emergencies) and health stations over one year. Fifty percent of respondents have never had any contact with Thai health staff. Most migrants seek health care, including ANC and deliveries, in Poipet, where facilities are basic and some practitioners are not qualified. Some private clinics may provide good services but at higher costs. Thus, it appears that many people self treat by buying packaged medicines (*ya chut)* at pharmacies, and using traditional remedies.

There is little or no outreach work, or preventative work, done with migrant communities. There is little or no assistance with language, which is a major problem. The hospital budget from the MOPH is for the Thai population and this has to cover services for

migrants. Thus, hospitals have to stretch their own budgets to subsidise migrants who can not pay the full fees.

Hospitals and health departments are responsible for containing communicable diseases on the border, however, outside of the hospital documentation and reporting there is no comprehensive means to do this. In addition, migrants are often looked down upon and there is a history of poor Thai-Khmer relations on this border (Pramualratana, 1995), which seems to still exist.

Women and vulnerability

It is generally reported that women in Southeast Asia have a relatively high degree of autonomy, and some authority, compared to women in many other parts of Asia. In the power structures of both public and private domains, however, they are generally subservient to men. The access men have to sex workers, with a continuing demand and a seemingly inexhaustable supply of girls and young women for sex work, attests to the strength of the patriarchal structures of these societies.

It has been demonstrated in the region that men normally refuse to wear condoms with their wives or regular partners, and even with the knowledge of an existing or pending HIV/AIDS epidemic women are powerless to change this situation. It is not only the power dimensions here but the association of condoms with prostitution and STDs, which stigmatises the use of condoms. This situation creates issues of trust, if a woman suggests using condoms she can be seen to be implying that her husband is unfaithful to her and therefore the possibility of infecting her. By not using condoms she is not implying or accusing her husband of anything. If a husband suggests using condoms he can arouse her suspicions of him being unfaithful.

Increasing awareness and understanding among women will not change the power structures but it is the first step in developing a community awareness of how sexual codes of conduct that are normative in some societies allow for the spread of HIV. The sexual double standard is expressed through similar proportions of respondents accepting that single men visit sex workers and agreeing with single men having other sexual relations apart from commercial sex, and yet far fewer agreed with young women having sexual relations. The small proportion, 4%, who find it acceptable for married men to visit sex workers may accurately reflect attitudes of many Cambodians. However, it may not reflect actual attitudes, or at least behaviours, in some of the communities on the border. Habits and customs can change in moving from more isolated areas to busy border areas and this has been noted for changes in sexual behaviour on the Myanmar border (see the accompanying report).

Higher knowledge of HIV/AIDS is by no means an absolute predictor of acceptance of, and a supportive attitude toward, PWHA but for many people the myths have to be dispelled before they will be accepting. In the attitudes to PWHA it was shown that higher knowledge leads to greater understanding. If people are keenly aware of how HIV spreads then they are aware of how it doesn't spread, and therefore will not be fearful of

PWHA. Thus women are disadvantaged again in that they may be more fearful . . was borne out in the survey with men having much more positive attitudes than women. And yet women may take on a disproportionate share of the burden of looking after people when they fall ill from AIDS related conditions.

Sexual violence reportedly is not uncommon for migrant women (Sophal & Sovannarith, 1999 Caouette et al. 1999). This study suggests that some women are vulnerable to direct sexual abuse including rape, whether this is by other migrants or uniformed men stationed at the border. They are also vulnerable to entering the sex trade through force or through economic need, either by migrating for this purpose, or as some informants stated, in entering the trade some stage after arriving at the border area.

In Aranyaprathet sex workers are delivered to customers over the border in Thailand. With limited language ability and their general status as Cambodians, as well as sex workers, they are open to abuses. They have openly stated that they fear or do not like some of the uniformed men, and they can be forced into servicing any number of men. They appear to have little power to insist on condom use. There also seems to be a market for virgin girls and some brothels cater for such a demand and of course it is not customary to use condoms on these occasions.

There was limited data on sexual networking outside of commercial sex but there was some quantitative and qualitative data to support other findings that suggest women enter into relationships for financial support (Lyttleton, 1997, Beesey, 1996). In these situations women may become a minor wife or mistress, or some may be 'forced' into sexual relations for favours or to avoid the wrath of authority figures. They are in a very vulnerable position with little power to protect themselves or to stop their partner from having other affairs. Many men who are mobile, such as officials, business men, traders, and truck drivers are in a position to financially support women (Pramualaratna, 1995; Beesey 1998)

Young men and risk situations

Marital status and living with families or outside families are further issues that must be considered for vulnerability of HIV. From the attitudes to sexual norms, and from much research conducted in Thailand, and more recently in Cambodia, it is apparent that part of the social life of many young men is visiting brothels with their friends (Tarr, 1997). Furthermore, such habits can be more frequent in border areas, especially when living alone or with friends. It is the culmination of loneliness, or just being away from the social constraints and family atmosphere, and a greater need of friends and things to do, combined with relatively easy access to sex workers, as is the case in Poipet (Decosas, 1996).

Young, single men were more informed than older men, and married men. It is quite likely that young men who visit brothels and talk about such visits manage to pick up information, and some may acknowledge the need to be informed and are alert to getting further information. However, overall awareness of HIV/AIDS issues was limited and the

myths and misconceptions that prevail make for some concern. And very few of these men acknowledged that they could be at risk for HIV infection, even though condom use is low (see below).

Consistent with young, single men having relatively high rates of knowledge those who stayed alone or with friends had higher knowledge than those who have families or stay with a family. Over 50% of the men are single but many of them stay with families. How much protection this offers them is somewhat speculative without further qualitative research, but it is likely that a family environment can provide some safeguards against customary practices that can lead to unsafe sex.

Married men are by no means free of risk, they did not demonstrate a good understanding HIV/AIDS issues, and some admitted to having extra-marital sex and some of those admitted to not using condoms. Others agreed with questions pertaining to certain practices and beliefs that potentially are very high risk, such as *kheun khru* – men being initiated into sex by sex workers, and equating male bravado with not using condoms. These and other beliefs are defined in the text as masculine behaviours.

Marital status can determine the level of risk that most single or married men or women may be faced with. Men being away from home seek out sexual outlets, generally this is with sex workers, but as discussed above migrant men may force themselves on migrant women. Women may be the objects of unwanted attention and abuse from the men they live alongside as well as from Thai uniformed men or others. This may lead women to seeking partners for protection and can lead to early marriage for some women.

The variability of risk and behaviour change

Low education and low income are associated with low knowledge and limited awareness of HIV/AIDS issues. This is a significant factor in determining the vulnerability of migrants for contracting HIV. It is a basic determinant in women's vulnerability. While 80% are earning below B2,000 per month the mean income is higher due to traders and a few other high income earners, but there is still a noticeable gap in women's earnings, B3,024, and men's earnings, B,3553.

If migrants enter into a high risk situation with limited understanding of the behaviours that spread HIV, and of the sometimes complex context of the risk situations, they will have little understanding of how best protect themselves in different situations. Income might limit their use of commercial sex but not entirely, and in any case it appears some men who cannot afford to visit sex workers may sexually exploit women in other ways.

Low income may lead to greater exploitation, it may lead to living in unhygienic conditions, it can lead to having unsafe sex if one does not want to purchase condoms. More speculatively, it may mean that some men resent their subordinate position and take out their frustration, or revenge, on women. Not using condoms may be a defiant act that also expresses male dominance and invulnerability, which may be supported by 15% of

respondents agreeing that men see themselves as brave and courageous by not using condoms.

Having set this picture it is important however, to note that knowledge alone does not lead to more protective behaviours. This is demonstrated in part by the fact that most of the men who have extra-marital sex are traders and labourers from Area 1, the main crossing point and market area, where respondents are most likely to have relatively good knowledge of HIV/AIDS. Higher income can mean more opportunities for finding sexual outlets and having multiple partners, and the findings in this study show that condom use is relatively low. Having multiple partners can also be a masculine expression of virility. While beliefs in the high risk masculine behaviours were found mostly among less educated respondents they do occur among all educational levels, and across all income levels.

Similar findings were found among those respondents who return home regularly to visit relatives. They have good knowledge but high proportions of them admit to extra-marital sex. However, they are more likely to have protected sex than those who do not visit home. This is consistent with the above findings and the earlier discussion on single men who have greater exposure to the outside world, including commercial sex, having good knowledge. In this case however, greater knowledge appears to lead to safer sex, but so far the evidence is greater for behaviour modification not occuring through knowledge alone. This is discussed in more depth in Chapter 4 on Trat.

The risk situation, and condom use

The risk situation for migrants is mainly in Poipet. Up to a thousand sex workers service Thai tourists and other visitors and local officials, including border personnel, in addition to local and visiting Cambodians, including migrant workers, many of whom commute daily to Thailand for work. Among the Vietnamese and Cambodian sex workers, qualitative findings and other reports suggest that it is Cambodian sex workers who are the least likely to use condoms. Among the clients who visit Cambodian sex workers it is more likely that Cambodian men, rather than Thai men, will not always insist on using condoms. This makes for low, or at least very inconsistent use of condoms between Cambodian sex workers and their Cambodian clients, and thus allows for possible STD or HIV infections.

Only 61 men admitted to extra-marital sex but most of these did not use condoms consistently. The 12 women who admitted to extra-marital sex never use condoms. This indicates that condoms are not used in non-commercial sexual relations as is found in numerous studies for the Thai context, except for perhaps an increased use among some groups of young people. Condom use has increased dramatically in Thailand over recent years but only after intensive programming and also many AIDS deaths. In border areas condom use appears to be lower than elsewhere in Thailand, and while condom use is rising in Cambodia it generally appears that use is inconsistent, and this is consistent with findings in Poipet.

There are a range of reasons for not using condoms, stigma as described above is one, having a sense that they reduce sensation is another (see discussion in Chapter 4 on Trat), and another may be cost. There has been free distribution in Thailand for several years for sex work establishments, but as a contraceptive method, or use for non-commercial sex, cost may be prohibitive for some. In Cambodia there is widespread social-marketing by PSI, and even in the border region condoms are available at discounted prices. Condom use is one of the main factors in reducing the rate of infection, thus supplies must be maintained and distribution points increased.

A large commercial sex network exists on the border region where besides working on the border women have followed the same routes of other migrant workers who travel further into Thailand, such as Bangkok. Trafficking has occurred for many years and only recently it appears to have reduced due to greater law enforcement in Thailand, especially of under age girls. It also appears that the border area here continues to attract Thai men seeking commercial sex with sex workers from Cambodia or Vietnam.

HIV prevalence is high and thus the spread of HIV goes well beyond commercial sex. Women are particularly at risk and yet few acknowledge their risk. In addition the knowledge and general awareness of how HIV spreads is not well understood. And there is very limited programming on either side of the border. Local and transient populations from both countries are at risk, this study however, has explored the vulnerability of migrants, and the findings support other studies which suggest that the background and mobility of migrants places them at high risk of contracting HIV.

Recommendations

The objective of this study is to provide an analysis of the HIV/AIDS situation in Aranyaprathet and Poipet and to determine the vulnerability of migrant workers who cross into Thailand. The findings of the study will hopefully provide local and national level service providers, policy makers, donors, and international agencies information, data, and analysis that will inform the development of effective STD/HIV/AIDS prevention and care programs. Migrants work under Thai employers, but many have limited contact with health officials, and sometimes with police, immigration or other officials, for they are daily commuters. They are just as likely to have contact with such officials in Poipet. Contact with sex workers and any other sexual contacts are more likely to occur in Poipet. For these reasons community mobilisation should occur on both sides of the border. However, this can occur independently rather than waiting on effective cross-border collaboration.

MSF is currently working in Poipet and other agencies are planning to expand STD/HIV/AIDS programming in the area. The government currently has no programs. Thus, there is the opportunity to move into community mobilisation building on some of the work MSF has undertaken and involving other agencies to develop new and broader community strategies. It is suggested that the following recommendations be used as a guide to develop trust and cooperation among all agencies and stakeholders.

1 Formation of a local working committee

At the district level a working committee can be established to coordinate activities. Problems within the migrant community within the environs in which they work in Aranyaprathet can be discussed, along with strategies to improve or develop health and HIV/AIDS services and preventative practices. All relevant government agencies, including health, immigration, police, labour and social welfare should be represented in the local committee, along with any other agencies supporting or planning to implement programs either in Aranyaprathet or Poipet. Migrant representatives, and if possible employer representatives, should also play a major role in the committee. If possible the committee should be linked to provincial and central bodies but have sufficient autonomy to respond to local needs and implement interventions. The initial impetus may come from the re-activated local AIDS committee but this should be expanded and its role clarified.

2 Organising local workshops

As an initial stage for the formation of the proposed local committee, a workshop can be organised in Aranyaprathet involving all individuals, organisations and agencies that will support and participate in the local committee. The workshop should include representatives from the Thai side of the border. The main item agendas would be the findings and recommendations of this study, and any other local studies could be included. This will be a means to provide important feedback on findings and discuss some of the pertinent issues. This can be followed by discussion on possible funding arrangements and the structure and function of the local committee. Discussion on possible activities can follow with the outline a proposed work plan.

3 Employers

Migrants are generally employed in businesses and industries that are in the private sector. Thus, the private sector should be encouraged to participate in discussions that are exploring strategies to improve health care for migrant workers. Meetings with employers, officials and other stakeholders must be balanced discussions, taking into account that employers are interested in profits. Employers can be made to realise that they have something to gain through working with government to develop effective health strategies. For minimal output they can maximise input from workers through a healthier workforce with less days off due to illness.

4 Programming in Aranyaprathet

It is likely that international agencies or Cambodian NGOs will soon implement activities in Poipet. This may not involve immediate cross-border collaboration; however, this may occur and perhaps should evolve rather than be a high priority in early program implementation. While cross-border sharing of ideas and possible pilot programs are explored interventions in Aranyaprathet should be able to compliment programming in

Poipet. Thus there could be NGO involvement, as well as more comprehensive government interventions HIV/AIDS work in Aranyaprathet. Under present circumstances with no NGO input it is unlikely that government can extend their current efforts. The major obstacles are that the MOPH provides no budget for migrants, in fact there is no budget of any sort of support for any basic services, be they health or welfare, for migrants.

This situation may change with the continuing registration system for migrant workers; however, no significant policy shifts are expected. The two possible avenues of support are, firstly, outside funding and support from an international agency or NGO; and secondly, if the government were to have a policy shift on seriously dealing with HIV/AIDS on major border areas. This second avenue is recommended and for the following reasons (disregarding humanitarian concern which does seem to be sufficient for budgetary changes at this point in time).

It is evident that Thai population groups are at increasingly greater risk from the spread of HIV on this border. On the general border area there is high HIV prevalence among sex workers, of whom many claim that their main clients are Thais. On the Cambodian side the military and police have very high rates of HIV infection as well. It is suspected that rates are higher than the national average or higher than non-border areas for Thai police, soldiers, and perhaps some immigration officials and other groups.

With support and funding the following interventions could effectively reach many migrant workers which would be very complimentary to any programming undertaken in Poipet.

- Gaining cooperation from Thais employers. This can include all sites but especially along the border sites where migrants are employed on a daily basis, and perhaps even more so on farms where seasonal workers are living and working. The knowledge of HIV/AIDS was lowest in both of these areas.

- Mobile teams of educators could disseminate information and HIV/AIDS leaflets and materials, as well as condoms, especially for the more isolated areas such as Area 3.

- Targeting family groups may assist in reaching women, who generally have low HIV/AIDS knowledge, and married men who had lower knowledge than single men. Women have low knowledge and for other reasons are vulnerable to HIV infection. They can be targeted through special leaflets, posters and other media materials, and through special venues, such as health stations.

- Peer education and special media materials with different themes can be used in Area 1, the immigration check point and main market area. For instance, the focus might be on condoms and reflection on one's own risk, rather than just on knowledge and general awareness.

- Identifying hotels and other venues where Cambodian and Vietnamese sex workers from Poipet are delivered to in order to provide HIV/AIDS information and condom supplies. This can be a focal point for condom distribution, and where social marketing or experimenting with discounted prices for condoms can be implemented.

- Exploratory research could be undertaken also to determine when seasonal work begins or if there are particular periods, or ways of determining when there are many newcomers who should be exposed to information on HIV/AIDS.

- As an adjunct to the above point migrants could be reached prior to their movement across the border and provided with information. The possibility of establishing networks to provide pre-departure information on conditions on the border and HIV/AIDS knowledge prior to migrating could be explored.

- Cross-border collaborative projects should include the development of IEC materials in Khmer language pertaining to STD/HIV/AIDS, and other health problems, which can then be disseminated in Aranyaprathet.

- Training should be offered to border officials and police, as well as military, on the situation of HIV/AIDS on the border and the necessity of all mobile groups being informed on safer sex practices. Cooperation should be sought from representatives of these groups for comprehensive programming in the area.

5 Community mobilisation

Effective programming is dependent on community involvement. Some of the findings of this study show that there are many misconceptions regarding the transmission and spread of HIV. Other findings suggest that knowledge alone does not lead to behaviour change. After many years of programming in Thailand and elswhere, there have been valuable lessons learnt, and the following guidelines for intervention are drawn from these experiences. These approaches are relevant to programming in both **Aranyaprathet and Poipet.** However, they will be mainly operative in Poipet where despite some fragmentation of migrant workers' communities there is more scope for working with more settled communities. Some communities may not be clearly defined as migrant workers as workers may sometimes be only part of a community.

- The first steps in community mobilisation are Steps 1 & 2 above, but no time must be wasted in bringing these plans and proposals down to the community level and testing ideas in the field through practical sessions with the migrants themselves. PRA activities are one way of doing this and can be one of the initial steps in designing programs.

- Most migrants are living in settled villages along the border, or otherwise in the Poipet township. Thus there are communities that can be identified. Some are seasonal workers in Area 3, living in Thailand and they will be discussed below, but

many of them may have some contacts in Poipet. Occupational groups, such as construction workers, especially if they are both living or working together can be identified as a community where peer and participatory approaches can be explored.

- The potential for peer education strategies can be explored among occupational groups, for example, sex workers or porters; and among village groups, for example, housewives or teenagers; and among farmers and labourers where the findings show that low income and low education can lead to limited knowledge and awareness. This approach can be developed through participatory approaches such as inventive training programs, PRA activities, or life-skills programs which are widely used and have proven to be effective in Thailand.

- Peer education can be used for a range of community groups, which include those population groups perceived to be at high risk. If the focus however, is clearly on the community this approach can help to avoid stigmatisation of certain groups, which can actually have a profound impact on safer sex behaviour. For instance, too much emphasis on sex workers can lead others to believe that sex with anyone other than a sex worker is safe. The high prevalence of HIV in Poipet indicates that HIV is spreading through sexual networks beyond sex work and thus it is a community concern that must be dealt with at the community level.

- Integrated programming, of which there are many examples, but one example could be literacy and/or health programs for women which include a component on HIV/AIDS. It could be income generation for women which includes HIV/AIDS programs. Such programs may help to build awareness among women which is lacking according to the findings, and also to reduce vulnerability through making them more self sufficient.

- All pharmacies and private clinics can be targeted and provided with up-to-date information on STD treatments and the situation of HIV/AIDS. This is more relevant to Poipet where the government should be encouraged to upgrade the basic medical services to deal with HIV/AIDS, which may soon be a major issue in care and not just prevention, as people fall ill.

6 Cross-border collaboration

Exchanges between any health sectors on both sides of the border can assist in providing information materials, distribution of condoms, and other prevention and care activities. For example, provision of materials in Khmer language should be available on the Thai side. Cross border collaboration does not have to be the beginning and end. The means to effective collaboration may evolve over time as programming develops on one or both sides of the border, arising out of identifying areas of need that can benefit from exchanges of information and regular communication.

Part 1 **CHAPTER 4**

CROSS-BORDER MIGRATION BEHAVIOUR AND HIV/AIDS TRAT – KOH KONG

The Border Area: Introduction and Background

4.1 Introduction

Khlong Yai is the district of Trat Province in south-eastern Thailand which borders Koh Kong Province in Cambodia. Trat has five districts, one municipality, and two pre-districts, which are the islands of Koh Kud and Koh Charng. Khlong Yai largely comprises a thin strip of land with the mountains of Cambodia on one side and the Gulf of Thailand on the other (see Map 4). The three sub-districts of the district of Khlong Yai are the areas of research in this study, Khlong Yai is also a sub-district, it has the main town and is in the centre of the other two sub-districts, namely, Mai Rud to the north, and Had Lek to the south. To the north of Mai Rud is the provincial centre of Trat, the town of Trat is 74 km north of Khlong Yai township, and from Trat to the tip of the south at Had Lek township, where the border crossing is situated, it is 165km.

Koh Kong was once a part of Thailand and some people in Khlong Yai had moved to live in Koh Kong. At various times after it was ceded to the French many people moved back to Thailand and they are generally bilingual in Thai and Khmer, and are referred to as the Koh Kong Thais. Over 90 years ago the Thais negotiated with the French for Trat and some of the islands while foregoing Srisophon, Battambang and Siam Reap.

The registered population of Khlong Yai is 17,241 (May 1997). This is only a three thousand increase since 1994 when it was 14,031 (Pramualratana 1995). However, with the large population of mostly undocumented Cambodian workers one estimate suggests a total population of 37,000 (Press 1999). In the past the population swelled with people fleeing the war in Cambodia (up until recently there was a refugee camp supervised by the Khmer rouge at the border on the outskirts of Trat municipality), today it is Cambodian workers streaming into Khlong Yai. Migrants are employed in fishing and related industries, sawmill factories, agriculture, sex work, and other occupations.

A small proportion of workers are documented through employer registrations with the Thai government. This registration system was initiated in 1996 with most workers registering for one year and extending to two years. Registrations were not extended in 1998 after government policy changes due to the economic downturn, however, another Cabinet resolution in the same year permitted further registrations and in an expanded range of industries in 54 provinces (Chantavanich 1999). Trat had over 3,000 registered workers in 1998, but there is no breakdown on districts. Most would be from Khlong Yai but other migrants working in gem mining and on rubber plantations further to the north may make up substantial numbers.

MAP 4: BORDER SITE

Most workers remain undocumented, such as those working in sawmills and labourers loading goods on ships - two groups who made up substantial proportions. Table 1.1 gives the estimated numbers of workers in each of the occupational groups selected for the study sample, a total of 2,360 (January 1999). The numbers may be an under-estimation in some areas due to changes that were occurring at the time of the survey, but would be higher than the current situation (September 1999) where stricter law enforcement appears to be reducing the numbers. It appears that the numbers have fallen over the past few years from estimates of 10,000 – 20,000 down to well below 2,000.

Table 1.1 Occupational Groups and Estimated Numbers

Fisher-men	*Fishery-related*	*Sea-laborer*	*Sawmill*	*Farm workers*	*Service-maid*	*Trader*	*Sex worker*
720	300	50	500	150	70	50	200

The Border Crossing

It is easy to enter into Khlong Yai by boat and so many migrants do this and avoid immigration. Just a few years ago people crossed freely from Koh Khong port to Had Lek, or by road many people used taxis, and there was "no serious examination of travel papers or citizenship in this neutral zone"(Pramualratana 1995). Now there is much vehicular traffic and an official immigration crossing point. Numerous fibreglass outboard motor boats ferry passengers between Had Lek and Koh Kong, which is just 20 minutes away. Many of these passengers are visiting relatives or doing business but have special Thai immigrant cards that permit them to do so freely. Fishing boats and other vessels can bring people into Thailand illegally.

It is difficult to estimate the number of migrants coming into the country illegally, or even the numbers of daily official border crossings; however, the following table shows the number of official crossings for 1997 to November 1998.

Table 4.1 Official Border Crossings in Khlong Yai

	Thai		Khmer	
Year	Entry	Depart	Entry	Depart
1997	7,595	7,677	33,310	28,155
1998	8,464	8,698	26,218	21,485

The volume of official crossings is smaller than in Aranyaprathet, but as stated, much of the mobile population pass unofficially, and many fishermen, who do not have to cross land borders, are often permitted to move beyond borders. While trading is common, and there are busy markets in the vicinity of the border, the volume of trade is smaller than in Aranyaprathet. There are two check points along the highway, Had Lek and Mai Rud, where police can check for smuggled goods or for illegal migrants.

At the southern tip of Had Lek sub-district, in Khlong Yai district, is the only official border crossing, several others to the north were open in past years when people fled the civil war, escaping across the mountains. The border crossing was officially opened as an immigration check-point in April 1998. Prior to this time it issued day passes or some passes up to a week. It appears that at this time it abolished locally authorised daily border permits, or permits that allowed seven day stays, changing to a system of more formal border passes or passports. Local protests by businesses and residents saw the permits reintroduced; however, disagreements between Trat and Koh Kong continued on how many days the permits should allow. Thai traders at least and other groups should now be able to obtain seven day passes. Locals complained that many people crossing the border did not have to use passes or permits as they were going to the casino.

A new casino with a resort and many facilities, including a cruise ship and duty free shop, recently replaced a smaller casino. Thais, and Chinese, or other nationalities from the region, can cross freely to go to the casino. This is one of several casinos established or planned for the Thai-Cambodian border. This casino is a lucrative business attracting many Thais and foreigners, and, according to the owners, adding to the local economy; however, some argue that it may add to social problems in the area (Bangkok Post 28/2/99). A few kilometres beyond the casino is a new area called Ban Mai or Talart Mai with many commercial sex establishments, which according to informants mainly serves visiting Thais.

Industries in Khlong Yai

To the north in Mai Rud sub-district agriculture is the main occupation where migrants are working. The work is seasonal so workers move from one area to the other, rubber is probably the most consistent work but does not employ many people. The economy of Khlong Yai district however, is dependant on the fishing industry, and saw mills have been a major industry as well. Khlong Yai sub-district has many saw mills but also a fishery industry, and in Had Lek fisheries and sea transport are predominant.

Saw mills

Sawmills employed many people and as undocumented workers they were generally confined to the factory compounds. Some employees are registered, apparently under another occupation as these factories are not included in the employer registrations in Trat. At the time the survey was taken, many sawmills had closed down due to the economic slow down but also due to logs being less available. On a return trip in June, six months later, almost all of them were closed, and people had returned home or taken up jobs in seasonal work in jelly fish farming, which was booming.

As in Aranyaprathet the logging industry has been hit by bans on logging, but perhaps half of the factories in Trat seemed to have secured a continued supply of timber from Cambodia until recently. When workers are laid off, or given time off, they risk venturing out from their relatively secluded life of living and working in the factory compound, and take the opportunity for visiting bars and sex workers (see Press 1999).

Fishing

The fishing industry is particularly large and includes fishermen from all adjoining countries including Myanmar. In fact registered workers, within the industries permitted to register workers, which included fishing, recorded Laos, Burmese, and Mon. In 1994 there were 480 registered fishing vessels with an estimated 1000 not registered (Pramualratana, 1995). The only estimate obtained recently suggests 350 registered boats and an unknown number of unregistered boats. The great majority of fishermen working in Khlong Yai and Koh Kong are Cambodians.

One report estimates at least 1000 Cambodians working on fishing boats in Khlong Yai which matches the number working in Sao Tong, the port in Koh Kong township (UNICEF, 1998). A key informant in Khlong Son/Khlong Makam area, the main fishing area in Khlong Yai, estimated 2,000 migrants working in fishing and related industries in the area. Most of the fish from Koh Kong is sold in Khlong Yai feeding into the transport, trading, and processing industries of Thailand (UNICEF, 1998).

There are two ports in Koh Khong where people may travel from and to, Sao Tong, which is part of Koh Kong town and nearby Pak Khlong, ferries are busy between these two points which are only five minutes apart. Also, only hours away to the south is Kampong Som, or Sihanoukville, the only international seaport in Cambodia. Fishing boats from the larger region dock here with captains and crew representing many nationalities, including Indonesian, Filipino, Burmese and Malaysian. In addition, there are off-shore islands where fishermen frequent, such as Koh Jao in Cambodian waters and Koh Khut in Thailand (Pramualratana 1995).

There are a range of types and sizes of fishing boats and some boats may be at sea for as long as a few months but small boats with less than five crew, and medium boats with five to ten crew, are more common. Small boats may stay out at sea only a few days while some medium size boats may stay out on average two to four weeks. Of an estimated 2000 boats in Koh Kong it is thought that most go out for only one week at a time (Cambodia Rapid Assessment, 1998). Thus, many boats may refuel and obtain food at a number of different mainland ports and islands from Thailand through to Vietnam, and sex workers are usually available at these stops. In a visit to the area in June most of the large boats were out in other territorial waters avoiding the bad weather in the gulf. Thus, there were fewer boats and fishermen in port, and in turn there were fewer sex workers. Generally there is no sex at sea, not even masturbation, due to superstitious beliefs. Thus, after days or weeks or months at sea fishermen seem to build up an appetite for sex which may include bouts of drinking and gambling and a general squandering of money (Pramualratana 1995).

Commercial sex

The risk situation in this border area is more pervasive than in Aranyaprathet in that the high risk environment exists on both sides of the border, even though areas in Koh Kong certainly appear to be higher risk situations. High risk situations also occur on some of

the local islands as well. While some migrants have a relatively stable environment there is continuous movement across the border by 'Koh Kong Thais' and various migrant groups, such as fishermen, traders and sex workers, but also includes tourists, officials, and others. All of these groups can contribute to spreading HIV across the borders to various locations. It should be remembered that borders are like magnets that attract people from far away locations. These people may or may not practice high risk behaviours in their place of origin but are tempted by, or have deliberate intention to, practice them in their destination, the border area.

The prevalence of HIV is well known and, as discussed in the next section, sex workers throughout the country have very high infection rates, but so do policemen. Fishermen are known to practice high risk behaviours in many ports throughout the region when they are away from home for long periods of time, and they have relatively high earnings. In Sao Tong and Pak Khlong areas in Koh Kong, and in Khlong Son in Khlong Yai district, and in various islands, the growth of sex industries have followed the growth of the fishing industries. Sex workers are drawn to the areas where fishing boats dock, and in border areas where police, military, traders and others may frequently seek the services of sex workers. As in Aranyaprathet sex workers are both Cambodian and Vietnamese, whether in Khlong Yai, Koh Kong or on the islands, in addition there are Thai women who work as indirect sex workers in Khlong Yai.

A report from Mahidol University, from a survey undertaken five years ago, explains that brothels in Aranyaprathet had changed to mostly indirect services due to government clampdowns. In Trat brothels still existed when the Mahidol survey was undertaken, although some places had changed to indirect sex venues. The police apparently have continued to monitor the situation and as in many places in Thailand there is some confusion over what is direct services and what is not. Thus, some places are thinly disguised, that is, not overtly exposing themselves as providing the direct services of a brothel, but nonetheless providing sexual services on the premises or nearby. Such services are not readily available in Khlong Yai township area, but just a short ride away it is different.

The red light area in Khlong Son, in the north of Had Lek, has thinly disguised brothels as well as many women who rent rooms in the vicinity and then walk into the entertainment area to find customers. The area in Khlong Son was documented in the Mahidol report, where it stated that up to 250 boats could dock. The report stated that in close vicinity to the port there were brothels, where Thai women worked, whereas further out in private dwellings there were Cambodian sex workers. Consistent with Aranyaprathet few Thai women work in direct sex work anymore, Cambodian women are in the majority with a substantial number of Vietnamese who make up the 400 or 500 women in the high season, with numbers dropping to as low as 100 when fishermen are not available. These women are part of the circular movement, following the fishermen or other customers as they ply their trade from Khlong Yai to the islands and to Koh Kong. Informants estimate approximately 1000 sex workers in the Koh Kong areas.

In contrast to Aranyaprathet many of the migrants are single men, or married men who have come without their families, although there are families and some single women. Many of the fishermen are single men, or married men away from their families, and this situation has contributed to the growth of the sex industry.

There has not been any NGOs working in the area until recently when CARE Thailand established a program. However, prior to this, from 1993-1998, Norwegian Church AID funded training and outreach programs with the hospital which also involved staff from the hospital in Koh Kong.

4.2 Public Health Situation and Services

In Khlong Yai district there is one 30 bed community hospital, in Khlong Yai municipal area. The closest provincial hospital is Trat hospital, 74 kilometres away. The hospital provides in-patient and out-patient services as well as some outreach. Hospital sources stated that the percentage of migrant patients they treat is currently at 49%. The following table provides in-patients and out-patients by ethnicity for the period 1994 to 1997. Only one of the staff speaks reasonable Khmer.

Table 4.3 Thai and Khmer Patients at Khlong Yai Hospital, 1994-1998

	Out-patient		In-patient	
	Thai %	Khmer %	Thai %	Khmer %
1994	6,205 (54.3)	5,217 (45.7)	947 (42.5)	1,281 (57.5)
1995	13,253 (68.1)	6,217 (31.9)	1,430 (49.5)	1,462 (50.5)
1996	20,924 (70.6)	8,696 (29.4)	1,737 (55.3)	1,404 (44.7)
1997	20,986 (62.3)	12,685 (37.7)	2,178 (52.5)	1,971 (47.5)

Migrants are a severe strain on the finances of the hospital as the available budget from the Ministry of Health only covers Thai patients. Many of the migrants are poor and cannot pay the full amount and so the hospital subsidises them. For each of 1997 and 1998 subsidies totaled over one million baht.

Communicable diseases are prevalent and many migrants have limited knowledge of good hygienic practices to prevent communicable diseases. The origin of many diseases is from inside Cambodia itself, however, poor living conditions on the border with no waste disposal and sometimes no running water increases their vulnerability to certain diseases. Some communicable diseases rarely found in Thailand, such as polio and filariasis, are occurring in the border region, albeit generally among relatively small numbers of Cambodian migrants. Typhoid and cholera are also prevalent among migrants, and malaria remains endemic to the area.

Documentation from the Khlong Yai hospital showing the main causes of death of Thai nationals in the past four years is listed in Table 4.4.

Table 4.4 Main Cause of Deaths, 1995 - 1998

Cause of death	1995	1996	1997	1998
Heart disease	35	18	18	3
Accidents	6	12	12	3
Cancer	6	2	2	1
Diabetes	4	2	2	2
Malaria	3	3	8	2
AIDS	3	7	14	10
Tuberculosis	0	0	0	4

Khlong Yai Hospital

Other community health services include seven small community health centres staffed by village health volunteers, and four health stations in the district, two in Had Lek, one in Mai Rud, and one in Khlong Yai. In the Khlong Son/Khlong Makam area the health station has 500-600 patients per month for minor illnesses, approximately 85% of these are local Thais and the remainder Cambodians. The most common ailments are probably general respiratory illnesses, including the common cold, and many people seek treatment after some type of accident. More serious illnesses are referred to the hospital. There are four staff and the only medically trained personnel are three nurses. The majority of patients are men and the costs incurred only cover the cost of medicines, most migrants can usually afford to pay the minimal amounts required. One of the staff speaks a little Khmer.

There are ten private clinics in the area and five pharmacies. At least one pharmacist still provides injections for minor illnesses.

4.3 STD/HIV/AIDS Situation

Sexually Transmitted Disease

STDs have reduced dramatically in recent years in Thailand, however, key informants regard them as a major problem in Koh Kong. The reduction of STDs in Trat and in Khlong Yai have been the result of increasing condom use in Thailand as well as an increasing ability to diagnose correctly and treat appropriately. However, the reduction appears to have been some years behind the declines in most other parts of Thailand. This may be due to the prevalence of STDs in Koh Kong that cross into Thailand via fishermen, sex workers, and other mobile populations. One informant in a health station suggested that the decline in STDs was only apparent since last year. One pharmacist suggested that it was only in the past couple of years.

Hospital officials suggested that STDs had reduced to being a very minor problem some years ago and a couple of pharmacists concurred with these reports. There is an STD clinic in the hospital but they have very few patients, thus the doctors were adamant that STDs have reduced dramatically over recent years. However, this does not account for

those who are self-treating, attending private clinics, and seeking treatment in Koh Kong rather than in Khlong Yai.

HIV/AIDS

HIV has been spreading in the area for some years and Trat, along with Aranyaprathet, has been a major route for HIV to spread from Thailand to Cambodia. Now the major concern is the spread of HIV in the border areas themselves, but also with STD and HIV rates higher in the Cambodian border provinces there is some fear of HIV spreading into Thailand from Cambodia. Koh Kong, in particular, has much higher rates of infection than the national average of Cambodia, considerably higher rates than in Khlong Yai district. In this section HIV/AIDS prevalence of Thai people in Trat is presented first, followed by results of testing of migrant workers in Trat, and comparable prevalence data in Koh Kong.

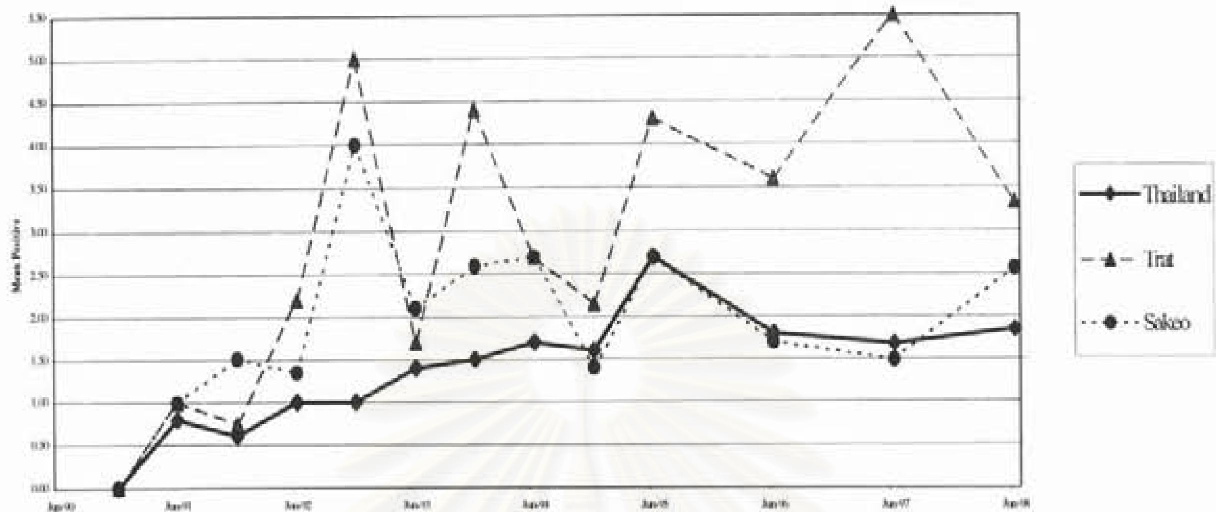
In the province of Trat in the last five years there have been 136 deaths and a total reported number of cases 1,150, including symptomatic HIV and full-blown AIDS. The ratio of men to women is 5:1 in favour of men. The number of full blown AIDS is 834 with a ratio of 4:1. Eighty percent of infections are reported to be through heterosexual sexual contacts and 7.3% through injecting drug use.

Pregnant women and sex workers continue to have higher rates of infection than the national average, see Tables in the previous chapter in 3.3, and comparable rates with sex workers in Koh Kong but lower rates than pregnant women. There were no figures available on pregnant women for 1998, ANC was substituted with 'married women', for further discussion on Koh Kong see below.

Table 4.5 Comparison of HIV Sentinel Surveillence Trat, Thailand and Koh Kong, Cambodia

Trat	June 94	June 95	June 96	June 97	June 98
Pregnant women	2.79	4.23	5.55	5.50	3.33
Sex workers	36.0	N/A	34.0	53.85	47.93
Koh Kong			1996	1997	1998
Pregnant women	N/A	N/A	5.26	19.50	N/A
Sex workers	N/A	N/A	52.10	52.00	42.6
Police	N/A	N/A	14.29	21.00	25.8

Figure 3.1 HIV/AIDS Sentinel Survey on Pregnant Women in Thailand and Selected Thai-Cambodia Border Provinces, 1990-1998



The highest number of AIDS cases in the province are in Khlong Yai district. Between 1995 and 1998, 46 people died from AIDS and there were 263 people known to be infected among the Thai population. Of course these statistics may not cover all deaths due to AIDS and most people do not know if they are infected. Considering the high rates of infection in Koh Kong, and among migrants in Khlong Yai, presented below, it would be expected that infection rates among the Thai population may be high as well. It should also be noted that a substantial number of the clients of sex workers in Khlong Yai and Koh Kong are from outside the province and thus if they are infected they will not appear in the statistics in Trat or Khlong Yai.

There are two sets of data which show the prevalence among migrant workers. The first set is sentinel surveillance over four years among groups that are regularly tested: CSWs, pregnant women, STD clinic attendees, and those donating blood (Table 4.6). The infection rates are consistently high, especially for sex workers - over 50% for three of the four years. In 1998 over 50% of the sex workers tested were HIV positive. Over 50% of these were 19 years old or younger (Table 4.6). Infection rates for pregnant women attending ANC average over 11% for the four years.

Table 4.6 Selected Migrant Population Groups Tested and Found HIV Positive

Population group	1995		1996		1997		1998	
	Test	Positive	Test	Positive	Test	Positive	Test	Positive
ANC	154	14 (9.1)	190	22 (11.6)	150	18 (12.0)	193	20 (10.4)
STD clinic	11	4 (36.4)	51	10 (19.6)	68	14 (20.6)	75	17 (22.6)
CSW	62	34 (54.8)	134	56 (41.8)	139	74 (53.2)	45	28 (62.2)
Total	227	52	375	88	356	106	268	37

Table 4.7 Sex Workers Tested in 1998 and Found Positive by Age

Age	Number tested	Number positive	Percentage positive
14 – 16	5	4	80.0
17 – 19	20	11	55.0
20 – 24	13	8	61.5
25 – 33	6	4	66.6
Total	45	28	52.6

The second surveillance set is taken from health tests of migrant workers who are registering for work. In 1997, 1037 migrants were tested. Of the 847 men tested, 113, or 13.3% were found to be positive. Of the 190 women tested, six women, or 3.2% were found to be positive. In 1998, 876 migrant workers were tested and of the 694 men tested 77, or 11.1%, were positive. Of the 182 women tested, eight, or 4.4%, were positive.

Table 4.8 Registered Migrant Workers Tested and Found HIV Positive by Age.

	Males				Females			
Age	1997		1998		1997		1998	
	tests	positive	tests	Positive	tests	positive	tests	positive
15-19	98	9	82	3	31	5	51	2
20-24	296	39	200	23	49	0	46	2
25-29	292	44	220	33	43	0	44	1
30-34	46	18	107	11	17	1	20	1
35-39	62	3	46	4	27	0	12	1
>40	53	1	39	3	23	0	9	1
Total	847	113	694	77	190	6	182	8

As shown in the following table, of the male migrant workers tested in 1998, fishermen had the highest rates of infection, 13.1%, general labourers were next, 8.9%.

Table 4.9 Registered Migrant Workers Tested and Found HIV Positive by Occupation 1998

Occupation	Males			Females		
	Tested	Positive	Percent	Tested	Positive	Percent
Fishermen	436	57	13.1	66**	4	6.1
Contractors*	180	16	8.9	84	4	4.7
Shrimp farm	3	-	-	5	-	-
Labourers	36	2	5.5	14	-	-
Agriculture	39	2	5.1	13	-	-
Total	694	77	11.1	182	8	4.39

* Contract labour or other work for a variety of usually short term work

** Fishery processing

In early 1998 a separate study of fishermen in four sites in Thailand conducted saliva tests of over 800 fishermen. Of the 99 Cambodian fishermen tested in Khlong Yai results confirmed in the laboratory showed that 20% were HIV positive. This rate of infection was higher than that of Thai and Burmese fishermen in other sites (Entz 1999).

The rates of HIV infection for fishermen, sex workers, and pregnant women are amongst the highest in Thailand. Pregnant women are usually taken as a measure of the prevalence in the general community, thus the HIV prevalence is particularly high in this border region. This reflects the situation in Koh Kong across the border in Cambodia where in 1997 pregnant women had rates of 19.5%, sex workers 52%, police 21%, and military 10%. The cross border mobility of workers, traders, businessmen and people visiting relatives facilitates the spread of diseases, especially HIV.

4.4 Methodology

Preparation and data collection

Development of the structured questionnaire was undertaken in November 1998 and preliminary research was undertaken at the same time. The survey was conducted in December and a return visit was made in June.

Table 4.10 Dates of Prepatory Work, Training, and Data Collection

Date of visits	Purpose of visits
17 – 18 November 1998	Collection of background information; observation of site; identify collaborating organisations
7 - 10 January 1999	Workshop to discuss ideas and cooperation local organisations; select assistants; testing questionnaire
10 – 14 January 1999	Workshop to train translators and test questionnaire. Collection of data over five days
11 –14 June 1999	To confirm data and to gain further qualitative data

In addition to the formal survey key informant interviews were undertaken with a range of Thai and Khmer officials including hospital staff, employers, a village headman, store keepers, and a captain of a fishing boat. Informal discussions with target group members were also undertaken. Some key informants accompanied researchers during their stay to provide support and further information.

ARCM staff collaborated with local individuals and organisations to prepare, plan, and implement data collection in the following ways:

1. Planning on-site was undertaken with generous support from staff at the Khlong Yai Hospital.

2. Data collection was undertaken through the support of three staff from the hospital who were the Thai counterparts with ARCM researchers. They also assisted in obtaining five male and three female volunteers from Koh Kong in Cambodia to conduct the interviews. These volunteers were fluent in Thai as well as their native Khmer language.

3. Security officials and other government personnel facilitated access to migrant workers for interviews to take place.

In addition to the above collaborative work outside consultants were brought in to provide advice on migration, population issues, and HIV/AIDS.

Constraints and limitations

Representative sampling

Proportional sampling was undertaken in order to determine the size the of sample of each occupation. At the time of the survey approximately half of the saw mills had closed down so it was difficult to determine an appropriate sample size. On a return visit in June almost all saw mills had closed down, thus the sample selected was partially representative of earlier this year or later last year rather than the current situation.

Access to migrant workers

There are many workers who have overstayed their permits or entered illegally, thus, some were not open to being interviewed. In addition employers were sometimes not cooperative, such as some of those in the saw mills. The nature of these businesses is quite sensitive, they have never been in the Thai government's employee registration system. Eventually access was gained to two factories and sufficient interviews were undertaken.

There was some difficulty in gaining access to sex workers at first as well. And there are some ethical concerns that should be considered here. The difficult access may have been due, in part, to journalists who had visited the area recently and taken photographs, and

thus the sex worker and owners were wary of any other outsiders coming in. In addition, before the survey the hospital official in charge of HIV/AIDS programs had conducted outreach among the sex work establishments. While he has fairly regular contact with owners and sex workers for some reason many sex establishments were raided soon after his visit.

The first attempt to reach sex workers was with the support of border officials but as they were not trusted this attempt failed. The next time was with a small team of researchers, the HIV/AIDS person from the hospital, and translators, who divided into small groups and they were successful in interviewing 13 sex workers. This is not a representative sample but under the circumstances it was decided that enough data could be gained from these interviews. On the return visit in June we were informed that the area was again raided by police after the survey and some people were detained. This is a sensitive issue in terms of brothels operating openly under more highly regulated enforcement of brothel closures in Thailand in recent years, which is discussed in the text of this report.

Ethical concerns

Interviewing people who may be defined as illegal either due to their immigrant status or their occupation is a concern. In this case sex workers may be determined as illegal under both categories of occupation and migrant status. In the immense amount of research that has been undertaken on commercial sex work in Thailand women's groups and other feminists have cautioned researchers and programmers on indiscriminate research approaches and potential adverse outcomes for the interview subjects.

This research is approached with this in mind but also with the knowledge that these women are one section of the migrant working population, and one of the most vulnerable sectors, and our understanding of their predicament is still limited.

It was made clear that all interviews were anonymous and confidential, and above all voluntary. Measures were taken so that none of the target group members were put under any stress, and hopefully not in any danger of being exposed to authorities. This protocol was stressed in workshops and training sessions.

Language

The questionnaire was translated into Khmer, and so some volunteers were able to conduct interviews by themselves after being accompanied with a Thai researcher on the first day or two. All volunteers were fluent in Thai as well their native Khmer and thus while there may have been minor difficulties in having all Thai instruction and using a translated questionnaire no real problems in translation were observed. Some Khmer interviewers found it quicker to translate for the Thai interviewer instead of reading from the Cambodian questionnaire.

Part II **FINDINGS:**

Migrants and Migration Behaviour

4.5 Demography of the Study Sample

The study sample consists of Cambodian migrants who are temporary residents in Khlong Yai District. Table 2 presents the numbers of respondents from the three areas or sub-districts selected for research.

Table 4.10 Respondents and Sub-district Plus Main Occupation and Sub-district.

Sub-district	*Number*	*Percent*	*Main Occupation*	*% employed main occupation*
Mai Rud (MR)	22	6.4	Agriculture	90.9
Khlong Yai (KY)	130	37.6	Timber factory	50.8
Had Lek (HL)	194	56.1	Fishing	52.6
Total	346	100.0		

Occupation

In addition to the three main occupations in Table 4.10 labour used in sea transport, which is primarily loading and unloading of general cargo or fishery products, accounts for a large proportion of the work of respondents in Khlong Yai and Had Lek, 24.6% and 12.9% respectively. Fishery related work, such as processing and packing, accounts for 9.2% and 18% respectively.

Fishing and fishery related accounts for 16.1% of respondents in Khlong Yai plus 70.6% in Had Lek. Sea transport accounts for 24.6% and 12.9% in Khlong Yai and Had Lek, respectively. Thus, these industries form the main occupations of respondents along with timber manufacturing in Khlong Yai, reflecting the actual situation of employment at the time of the survey. However, in a visit to the area in June even more saw-mills had closed down. Many people it seems moved from the saw-mills to take up seasonal work in jelly fish farming.

Service/maids, which is predominantly maids in private homes but is also waitresses, accounts for 6.9% of migrant workers in Khlong Yai, and CSWs account for 6% of respondents in Had Lek (Table 3). Table 4.11 shows the breakdown of workers in each occupational category according to sub-district.

In most occupations there is some demarcation between what men do and what women do. Much of the work is demanding and dirty and in sea transport and timber processing women have the lighter jobs (see Figure 4.3).

Table 4.11 Sub-district by Occupation

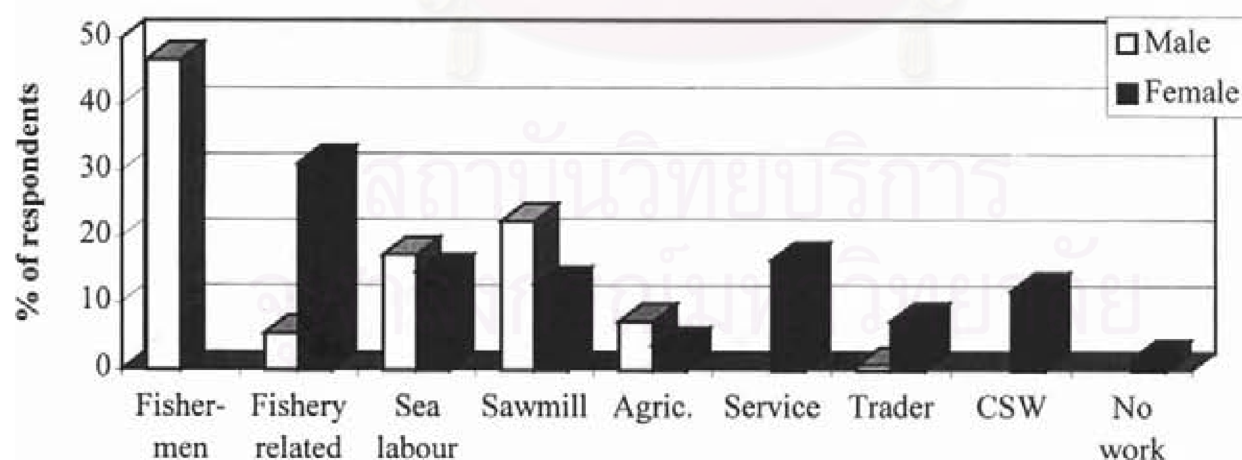
Occupation	*Sub-district in number and (percentage)*			*Total*
	Mai Rud	*Khlong Yai*	*Had Lek*	
Fishing	-	9 (6.9)	102 (52.6)	111 (32.1)
Fishery related	-	12 (9.2)	35 (18.0)	47 (13.6)
Sea transport labour	-	32 (24.6)	25 (12.9)	57 (16.5)
Saw-mill	1 (4.5)	66 (50.8)	-	67 (19.4)
Agriculture	20 (90.9)	1 (0.8)	-	21 (6.1)
Service/maid	1 (4.5)	9 (6.9)	8 (4.1)	18 (5.2)
Trader	-	-	10 (5.2)	10 (2.9)
Sex worker	-	-	13 (6.7)	13 (3.8)
Unemployed	-	1 (0.8)	1 (0.5)	2 (0.6)
Total	(100.0)	130 (100.0)	194 (100.0)	346 (100.0)

Table 4.12 Sub-district and Occupation

Sub-district	*Fisher-men*	*Fishery-related*	*Sea-laborer*	*Sawmill*	*Agric.*	*Service-maid*	*Trader*	*CSW*
MR	-	-	-	1.5	95.2	5.6	-	-
KY	8.1	25.5	56.1	98.5	4.8	50.0	-	-
HL	91.9	74.5	43.9	-	-	44.4	100.0	100.0
Total %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Plus 2 unemployed

Figure 4.2 Occupation and Gender

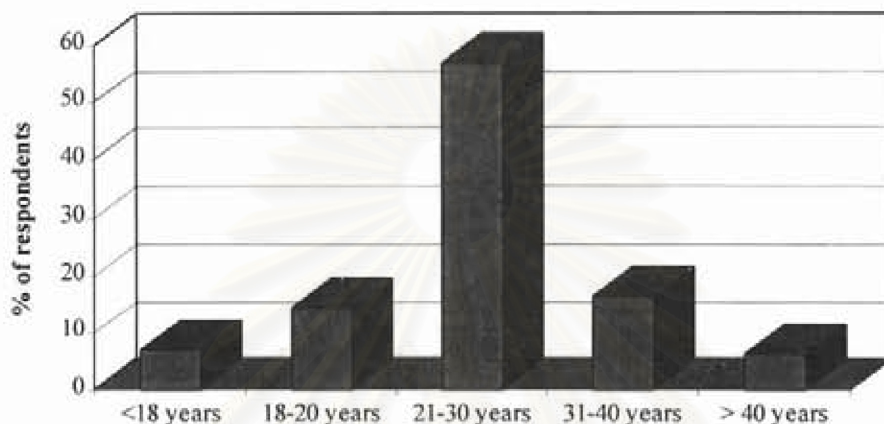


สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Age

Most respondents are between the years of 21 to 30 years of age, 56.8% of the total sample. Below 18 years is 7% and 18 to 20 is 14.2%. Over 40 years is 6.2% and between 31 to 40 years is 15.7%. Men are predominant among the younger age groups, up to approximately 30 years of age, mean age was 26. Women were predominant in the older age groups, mean age 27 years old.

Figure 4.3 Age of Respondents



Marital status

There are slightly more married respondents, 48.5%, than single respondents, 47.1%, the remainder are either divorcees, 1.2%, or widow/ers, 3.2%. There are 10 widowed women and three divorcees, among the men there is one widower and one divorcee. Most women are married, 58.7% (n=64), compared 29.4% (n=32) who are single. Most men are single, 55.3% (n=130) compared to married men, 43.8% (n=103).

Figure 4.4 Marital Status by Gender

There are more single people in Trat than there were in Aranyaprathet mainly due to single fishermen but single people are also apparent in other occupations, see Table 4.13. There are fewer divorcees and widows than in Aranyaprathet with only four divorced respondents but still a relatively high number of widows which is common, due to the war.

Table 4.13 Single Status and Occupation

Status	*Fisher-men*	*Fishery related*	*Sea-labour*	*Saw Mill*	*Agric.*	*Service -maid*	*Trader*	*CSW*
Single %	67.9	27.7	35.1	37.3	42.9	50.0	20.0	76.9

Education

As shown in Table 6, of the total sample 17.6% has no formal education, 37% have 1-5 years of education (with 13.9% having completed fifth year), 35.5% have 6-9 years (with 4.9% completing ninth year), and 9.8% had over nine years.

Women are distinctly over represented in the cohort of no formal education as can be seen in Table 6, 33.9%, as opposed to 10.1% of men who have had no formal education. They are still over represented in years 1-5 but less so, and then clearly under-represented in 6-9 years, 44.7% of men as opposed to 15.6% of women.

Table 4.14 Education by Gender

Education	Male	Female	Total
None	24 (10.1)	37 (33.9)	61 (17.6)
1-5 years	80 (33.8)	48 (44.0)	128 (37.0)
6-9 years	106 (44.7)	17 (15.6)	123 (35.5)
> 9 years	27 (11.4)	7 (6.5)	34 (9.8)
Total	237 (100.0)	109 (100.0)	346 (100.0)

Women's lower education is reflected in educational levels of different occupations. The percentage of all respondents with five years or less of schooling is particularly high in the female dominated occupations as shown in Table 4.15.

Table 4.15 Female-dominated Occupations by Education

Occupation	Five years or less education in *	% of women in occupation
Fishery related	79.0	72.3
Service/maid	77.8	100.0
Sex workers	69.3	100.0
Traders	50.0	80.0

*Five years or less includes No Formal Education with 1-5 years of education.

All other occupations which are male dominated had proportions of 42.9% to 50.7% of people who had five years of schooling or less. Thus the only relevant difference in educational levels cross-tabulated with occupation is between female dominated and male dominated occupations.

Literacy levels are generally low in Cambodia and this may be reflected in the proportion of people who have no formal education or five years and less, 54.6%, and many in the cohort of 1-5 years did not complete five years. Many of those who have some formal education may have had interrupted schooling due to civil war and repeated dislocations; however, some may be self taught or received an education through temples. Apart from the question on education there is no variable to determine the degree of literacy. However, given that the study sample are working in Thailand and working with Thai employers, proficiency in Thai was questioned and often tested as a variable in responses on knowledge, attitudes and behaviour.

Thai language proficiency

Many could speak Thai but 67.1% have little or no Thai language skills. A similar number said they could not understand Thai, 61%. The remainder had moderate or good comprehension and speaking skills (see Table 4.16). Over 80% stated that they could not read Thai at all and more than 90% said they could not write Thai. These relatively high proportions of Thai illiteracy and language skills indicate how the study sample is representative of the migrant workers and not the local populations. Local people in Khlong Yai who are living in Khmer or mixed Thai-Khmer villages may be bilingual as many are former residents of Koh Kong, before it became part of Cambodia; however, the majority of Khlong Yai residents speak only Thai.

Table 4.16 Thai Language Skills

Level of Skill	Spoken Thai	Comprehension	Reading Thai	Writing Thai
None	32.7	24.9	81.8	90.5
Little	34.4	36.1	12.0	6.6
Moderate	17.9	21.4	4.0	2.6
High	15.0	17.6	2.0	0.3
Total	100.0	100.0	100.0	100.0

The following variables are cross tabulations with comprehension and spoken Thai. Reading and writing was considered less important and the numbers who could read and write are much lower, so the analysis was confined to spoken Thai and comprehension. Given the high degree of consistency between the two, comprehension and spoken Thai, they are analysed together, but in the tables are shown separately.

There was a direct correlation with having Thai language skills and having lived in the border area for some time. Those who had been in the area longest had higher proportions of respondents with moderate or high skills in speaking and comprehension. The range

was between 6% of those who had been in the area for less than six months to over 30% for those in the area for over four years, see Table 4.17.

The only occupational group with distinctly high proportions who have good Thai language skills is service/maids, 61% claim that they have a high degree of skills. Most of these are maids live in Thai families and most of the waitresses would be working in Thai restaurants.

Table 4.17 Levels of Skills in Comprehension of Thai by Length of Stay

Level	≤ 6 months	7-12 months	1-2 years	2-4 years	> 4 years	Total
None	54.5	36.7	18.8	12.3	5.4	24.6
Low	30.3	48.3	48.4	28.8	27.0	35.9
Mod.	9.1	10.0	20.3	34.2	31.1	21.7
High	6.1	5.0	12.5	24.7	36.5	17.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 4.18 Levels of Skills in Spoken Thai by Length of Stay

Level	≤ 6 months	7-12 months	1-2 years	2-4 years	> 4 years	Total
None	60.6	60.0	23.4	19.2	6.8	32.6
Low	27.3	30.0	51.6	32.9	31.1	34.4
Mod.	6.1	5.0	12.5	28.8	31.1	18.1
High	6.1	5.0	12.5	19.2	28.4	14.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

There is no significance, and no distinct correlations with gender and Thai language skills. Men have slightly higher proportions of low level skills, and higher proportions of moderate skills in spoken Thai and comprehension, but greater proportions of women have high levels of proficiency.

Most of those over 40 years of age have low levels of skills, and many of these have no Thai language skills. Respondents under 21 years of age have matching proportions with high levels of skill when compared with the two older age cohorts, 21-30 and 31-40. However, they are distinctly lower in moderate and low skills. The proportion of young people with no skills is particularly high. This may indicate that they are newcomers and have not yet acquired skills, for the two middle age cohorts have high proportions in moderate as well as low levels of skills.

Table 4.19 Level of comprehension and spoken Thai by Age

Level	< 21 years		21-30 years		31-40 years		> 40 years	
	Comp.	Spoken	Comp.	Spoken	Comp.	Spoken	Comp.	Spoken
None	39.7	47.9	21.9	28.1	17.9	28.6	19.0	33.3
Low	30.1	24.7	35.2	36.7	37.5	33.9	61.9	47.6
Mod.	12.3	9.6	24.0	20.4	28.6	21.4	9.5	14.3
High	17.8	17.8	18.9	14.8	16.1	16.1	9.5	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

4.6 The Migrant Worker: Migration Behaviour and Working Conditions

Origins: home town and pre and post-migration

Before moving to the border area, that is, in their previous place of residence or in their home towns, the most common form of work was agriculture, with 33.2% most likely farming on family farms. A substantial proportion, 22.7%, were students, with 14.3% unemployed. The remainder included traders, contract labourers and fishermen.

Kampot was the most common home town for respondents, followed by: Kampong Cham, Koh Kong. Phnom Penh, Takeo, Prey Veng , Kandal. Small numbers came from, Svay Rieang, Battambang, Kampong Speu (see Table 4.20 and Map 5).

For 74% of the respondents this was the first time they had migrated or moved from their birth village. Of the remaining 26%, 43 respondents, or12.7% of the total sample, gave their first move as Koh Kong. Thus, they moved to Koh Kong and then to Khlong Yai it appears, which is in effect the same linear movement of migration; therefore, only 15.4% of the respondents have previously migrated. Their movement is recorded in Table 4.20.

The question that asks 'if you return to Cambodia where will you return to', seeks to determine what they perceive as their hometown, or at least, where they will settle. Most people indicated their hometown as the place they would return to. In most cases however, there was a small proportion who would not return to their hometown. The exception was Koh Kong where 38 stated it was their hometown, but 51 stated that this would be their destination if they were to return to Cambodia.

Only 59.7% of respondents, n=207, could answer the question regarding other people in their village coming to work in Thailand, the remainder did not know. Of the total sample 32.3% claimed that many people from their village have come to work in Thailand, 27.3% said none or a few. This was in variance with the findings in Aranyaprathet where 70% responded that many people in their village had worked in Thailand. Over 60% of respondents did not know if people in their village worked overseas, and only 18 people responded that they knew someone.

Table 4.20 Hometown and Return Destination by Province

Province	Hometown by no. and %	Where will return to by no. and %
Banteay Meanchey	2 (0.6)	1 (0.3)
Battam Bang	9 (2.7)	7 (2.1)
Kampong Cham	42 (12.4)	38 (11.6)
Kampong Chnang	4 (1.2)	7 (2.1)
Kampong Speu	7 (2.1)	5 (1.5)
Kampong Thom	25 (7.4)	18 (5.5)
Kampot	75 (22.1)	64 (19.5)
Kandal	24 (7.1)	22 (6.7)
Koh Kong	38 (11.2)	51 (15.5)
Kratie	4 (1.2)	3 (0.9)
Phnom Penh	31 (9.1)	33 (10.0)
Prey Veng	26 (7.7)	22 (6.7)
Pursat	2 (0.6)	1 (0.3)
Siem Reap	3 (0.9)	3 (1.1)
Stung Treng	1 (0.3)	-
Svay Rieng	12 (3.5)	13 (3.8)
Takeo	28 (8.3)	28 (8.1)
Other	6 (1.8) cannot identify	13 (4.0) (not returning)
Total	339 (100.0)	329 (100.0)

Crossing the border and documentation

Many respondents crossed the border at the only official crossing check-point at Had Lek, the remainder, 34.3% (n=119), did not pass by this route but crossed into Thailand ,most likely by boat. This is quite common given the fishing trawlers, cargo boats, and passenger or other private boats which travel from Cambodia and dock in Thailand. Some fisherman have registered through the government employer registration for migrant workers, and others may have authorised permission to work for Thai boats and are thereby allowed in the gulf. Others may not be legal but work in the gulf of Thailand and sometimes come to shore. Fifty percent of the fishermen said that they did not pass the immigration check-point; however, 26.2% of all fishermen claim to have employer registrations, and approximately half of those with such registrations did not cross the official check-point. Thus, it appears that approximately 35% of fishermen in the study sample are undocumented, however, their status is uncertain.

Sixty percent of the traders did not pass the official check-point, and among all the other groups substantial proportions did not pass the official check point as well; however, between 57% and 80% of all other occupational groups *did* pass the check-point. The

percentage of respondents from HL, who are primarily fishermen, were less likely to pass the check-point than those from KY or MR.

In addition to fishermen having migrant worker registration, 19% of those employed in sea transport have such registrations, as do 15% of saw mill workers, 11.3% of maids, and 6.3% of agricultural workers, see Table 4.21. In Trat saw mills and sea transport were not included in the government registration system, thus it is not clear how they obtained such registration. Employer registrations and the possession of immigration cards were less common in MR than the other two sub-districts.

Table 4.21 Occupation by Mode of Entry

Occupation	Pass via Immigration	Did not pass	Total	Worker registration
Fishermen	55 (49.5)	56 (50.5)	111 (100.0)	27 (26.2)
Fishery related	35 (74.5)	12 (25.5)	47 (100.0)	-
Sea transport/ Labour	40 (70.2)	17 (29.8)	57 (100.0)	11 (19.6)
Sawmill	44 (65.7)	23 (34.3)	67 (100.0)	9 (15.0)
Agriculture	13 (61.9)	8 (38.1)	21 (100.0)	1 (6.3)
Service/maid	15 (83.3)	3 (16.7)	18 (100.0)	2 (11.8)
Trader	4 (40.0)	6 (60.0)	10 (100.0)	-
CSW	10 (76.9)	3 (23.1)	13 (100.0)	-
Total	216 (62.8)	128 (37.2)	344 (100.0)	

Plus 2 unemployed (1 passed, 1 did not pass)

All occupational groups have relatively equal representation among those who state that they have Cambodian identification cards. While almost 40% of respondents did not have identification cards, most of them claimed to have legal documents: 68 have labour cards as they were registered by the Thai government, and 41 hadve special immigrant cards. Nineteen had green immigrant cards which means they are ethnically Thai who had been living in Koh Kong but moved back to Khlong Yai before November 15, 1957. Twenty one have white immigrant cards which also confers resident status but for those coming to Trat from Koh Kong after November 15.

Pre-Departure and Migration Process

The majority of respondents, 50.7%, claim that they came to the area on their own initiative, with a further 41.2% being encouraged by a friend or relative (see Figure 4.4). Only 17 respondents stated that an employer, or Thai or Cambodian agent supported them in migrating. This is very similar to Aranyaprathet and thus strongly suggests that agents have an extremely minor role in current migratory processes, at least to border areas, they play a greater role in longer distance migration (Sophal and Sovannarith).

In the past they may have played a greater role and if they still did they could have been an entry point in reaching migrants; however, their role seems to have been an exploitative one in the past (Phal 1997). Nonetheless, 34 respondents claim that they paid agency fees when questioned. It appears that some may have paid a friend or relative who helped them in the process or gave them the necessary leads. The most common expenses are in the range of B1,500 to B2,000.

Thus, those who say they came on their own initiative suggests that from stories of others they have made a decision to migrate by themselves. This corresponds with findings that only 42.3% had any prior knowledge of conditions on the border, (see Figure 4.5). There was no attempt to understand the degree of prior knowledge, but we can speculate that those who were supported by friends obtained some helpful information, as respondents did state that the prior information they obtained mainly came from friends or relatives.

Figure 4.5 Encouragement to migrate, by percent

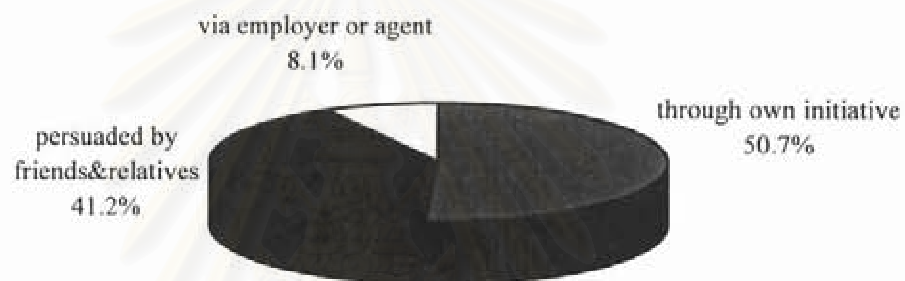
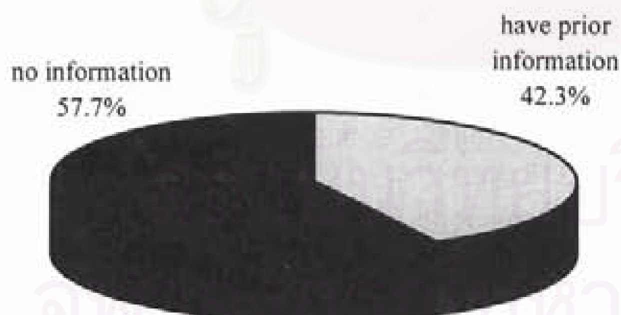


Figure 4.6 Information prior to migrating



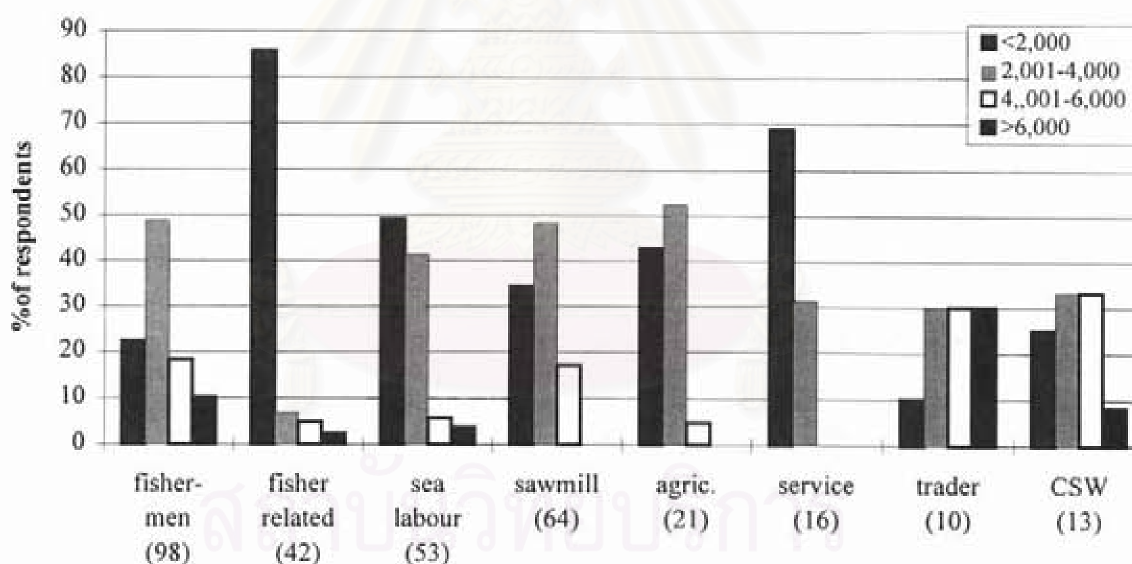
Regarding the question of what expenses were incurred in crossing the border, responses appear to be more to do with travel expenses, and for some may include costs incurred for agents or friends, as stated above. Many respondents had no costs, 23.1%. Most people claim costs of less than B1,000, 49.3%, while 19.9% claim costs between B1,000 to B2,000, only 25 (7.2%) respondents quoted figures beyond B2,000.

Income and Savings

Over 90% of the study sample works in Thailand, including fishermen in the gulf of Thailand. There is a small number who commute daily, weekly or monthly. This is in contrast to Aranyaprathet where most respondents are daily commuters, and over 90% of all workers receive wages on a daily basis, although agricultural workers were under-represented. In Trat, 43.1% of the total sample receive earnings on a daily basis and at a similar rate as that of Aranyaprathet, B60-80 per day; 34% are paid on a monthly basis, and 22.4% are paid per job.

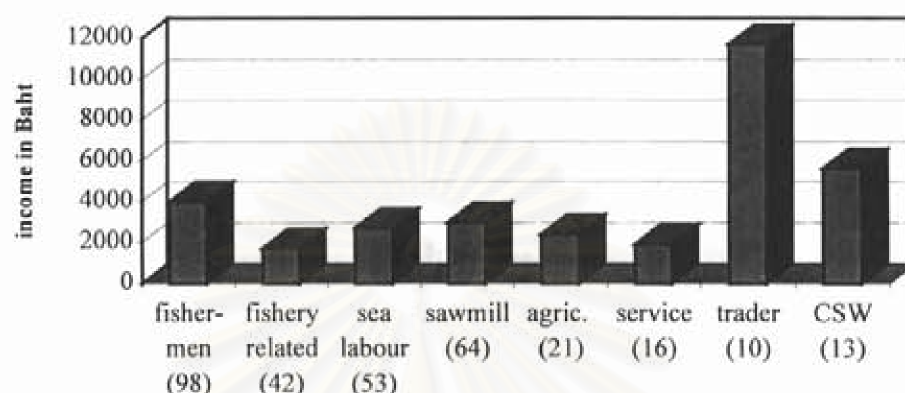
The majority of employees in three occupational groups receive earnings per day, namely, fishery related, sea transport, and the saw mill factory. Fishermen are predominantly paid per job; with agricultural workers and service/maid workers receiving wages monthly. Fishermen have the highest earnings with low proportions in the below B2,000 category, Figure 4.6 clearly shows those categories that are earning below B2,000. Fishermen have high proportions in the categories above B2,000, and incomes above B6,000 per month are mostly fishermen, 10 respondents, and the other two males are sea transport labourers. Five women included in the above B6,000 category are three traders, one fishery related employee, and one sex worker.

Figure 4.7 Occupation and Income



Traders had by far the highest means of income followed by sex workers and then fishermen. However, as the numbers of fishermen are high and the numbers of the other two categories low, plus the low incomes of other female dominated occupations (as shown below), the mean income of men was substantially higher than that of women, B3,412 compared to B3,216, despite high earnings of female traders and sex workers.

Figure 4.8 Means of income by occupation



Women are under represented in the B2000-4000 group and over represented in the category below B1500 (Table 4.22). As discussed in the demographics where women's lower education is reflected in female dominated occupations, women's lower incomes are reflected in two of those three occupations, namely, fishery related work and service/maid positions. The third occupation of sex workers had a much higher income.

Table 4.22 Income by gender

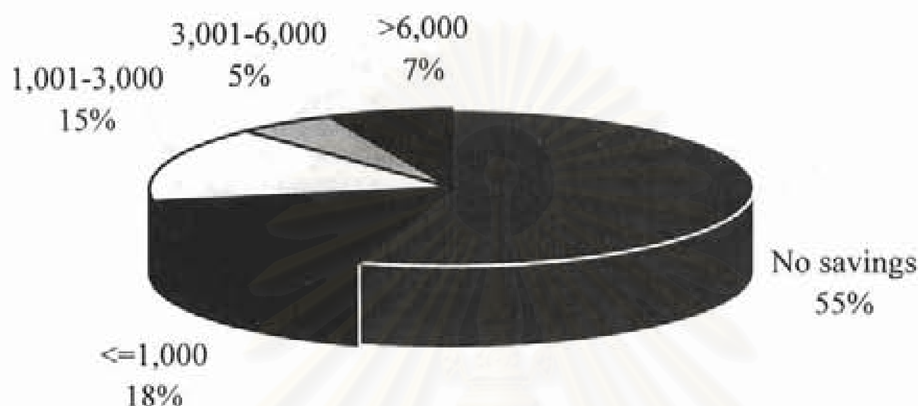
Income	Male	Female	Total
<500	1.8	4.0	2.5
501-1000	6.0	21.2	10.7
1001-1500	6.0	25.3	12.0
1501-2000	16.5	15.2	16.1
2001-4000	48.2	22.2	40.1
4001-6000	16.1	7.1	13.2
>6000	5.5	5.1	5.4
Total	100.0	100.0	100.0

Savings

With low wages for most people it would not be expected that they would have high savings. Most people claimed to have no savings, 53.5%. Of those who did have savings over 70% had less than B3,000; however, over 20% have saved over B6,000. Table 4.8 shows these percentages per the total sample, thus 33% have less than B3,000, and 7% have over B6,000 in savings.

Of the thirty people saving over B6,000 12 are fishermen, five were from sea transport labourers, and four from the saw mill. However, this disguises the fact that fishermen also have high proportions of respondents with no savings and comparably low proportions with savings below $3,000. Thus, fishermen have comparably high earnings but low savings which is consistent with qualitative findings and findings elsewhere where fishermen are known for squandering their earnings (Pramualratana 1995; Beesey 1998).

Figure 4.9 Savings



Contact with relatives, and remittances.

Almost 50% of the total sample have contact with relatives in Cambodia, with 131 respondents, or 39% of the total sample, having a father or mother who they contact, and 22, or 7% having a husband, wife or child, and for eight respondents, 2.4%, it was a friend (Figure 4.9). Thus, the many respondents are apparently attempting to support parents back in Cambodia and this is further borne out by many respondents sending remittances to parents. Of the 48.4%, or 172 respondents who have contact with relatives136 send money home. Almost half the sample are sending over B5,000 annually, and 12% are sending more than B20,000. Most respondents are sending money by themselves or through friends or relatives, and most, 35% (n=98) of the total sample, are sending to parents/relatives (Figure 4.10). In Aranyaprathet just under 50% of respondents also claim to have contact with relatives or home town, but fewer are sending money home and only 19% are sending to parents. As with Aranyaprathet cross tabulations did not demonstrate any associations with gender, marital status, or occupation.

The difference in Aranyaprathet was that there are fewer single people, and thus fewer people living outside families. While many people in Trat are not in contact with relatives those who are in contact are more likely to send money home. Given the number of single respondents it is expected that they would be supporting parents, in addition, some married people are sending money to their spouse or family.

Consistent with 50% of respondents having contact with relatives, 64.1% of the total sample responded that they never or rarely visit their hometown – 58.9% of men and 75.2% of women. Others confirmed that they have no contact. Of those who return 77, or 22.3% of the total sample, visit once or twice a year, and the remainder, 47, or 13.6% visit more frequently, see Table 4.23.

Figure 4.10 Contact with Whom

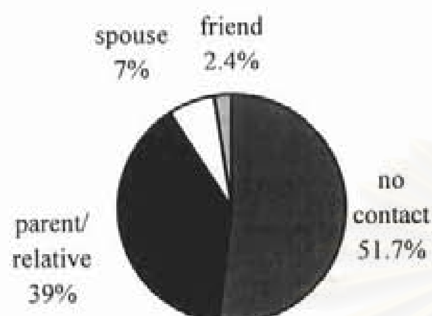


Figure 4.11 Remitting Money to Whom

Table 4.23 Frequency of Visiting Home by Sub-district of Destination

Visiting frequency	*Mai Rud %*	*Khlong Yai %*	*Had Lek %*	*Total %*
Never	12 (54.5)	92 (70.8)	117 (60.6)	221 (64.1)
Once-twice a year	10 (45.5)	27 (20.8)	40 (20.7)	77 (22.3)
Regularly	-	11 (8.5)	36 (18.7)	47 (13.6)
Total	22 (100.0)	130 (100.0)	193 (100.0)	345 (100.0)

In response to when was their last visit home, 186 respondents or 53.8% confirmed that they never returned home. Of the remainder, 17.6% said in the last three months, 17.1% in the last 4-12 months, and 11.6% over a year ago.

Place of residence and staying with whom

In contrast to Aranyaprathet the study sample was equally divided between those who are living with family and those who are living with friends, plus 8.4% who live alone. The major proportion, 41%, live with same sex friends, a small proportion live in mixed sex households, 3.8%. Families comprise two categories, nuclear family and extended family. Nuclear family is where the respondent is living with a spouse and children, and comprises 27.3% of the study sample. Extended family is divided into two categories, the first is a compound family where several families may live in one compound, 7.8%, and the other a more traditional extended family with extended kin living under the one roof, 11.3%. These categories are presented in Table 4.24 cross-tabulated with marital status, however, for further cross-tabulations, such as, occupation in Table 4.25 and AIDS knowledge, the categories are collapsed into just two categories, family and outside

family. The latter category includes those living with same sex and mixed sex friends, as well as those living alone.

Respondents staying with friends generally means living in partitioned rooms, or a series of small rooms provided by the employer, such as the saw mill where 36 of the respondents were staying. Other respondents staying with friends were fishermen, where 60 of them were staying on their boat.

Of those who stay with friends most are single, 72.6%, and most are male, 88%. From the demographic profile most fishermen are single whereas in the other major occupational groups most people are married (see Table 4.25). Married respondents may be living alone of course, and the data shows this to be the case (see Table 4.25). Married people or single people living alone or with friends would generally be more likely to have risk behaviours associated with commercial or non-commercial sex. Most would be men but women are susceptible to entering into the sex industry, or being victims of sexual abuse, as was the case in Aranyaprathet.

Table 4.24 Living with Whom by Marital Status

Live circumstances	*Single*		*Married*		*Divorce*		*Widow*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Family (parent)	8	5.0	80	47.9	1	25.0	5	45.5	94	27.5
Family, extend.	19	11.9	18	10.8	-	-	2	18.2	39	11.4
Family compd.	9	5.6	17	10.2	-	-	1	9.1	27	7.9
Friend,same sex	99	61.9	41	24.6	-	-	-	-	140	40.9
Friend, mix sex	7	4.4	6	3.6	-	-	-	-	13	3.8
Alone	18	11.3	5	3.0	3	75.0	3	27.3	29	8.5
Total %	160	100.0	167	100.0	4	100.0	11	100.0	342	100.0

Table 4.25 Living with Whom by Occupation

Living with whom	Nuclear family No. %	Extended family No. %	Outside family No. %	Total No. %
Fisherman	9 (8.3)	18 (16.5)	82 (75.2)	109 (100.0)
Fishery related	22 (46.8)	17 (36.2)	8 (17.0)	47 (100.0)
Sea transport	23 (40.4)	16 (28.1)	18 (31.6)	57 (100.0)
Sawmill	22 (32.8)	7 (10.4)	38 (56.7)	67 (100.0
Agriculture	3 (14.3)	1 (4.8)	17 (81.0)	21 (100.0)
Service/maid	8 (44.4)	4 (22.2)	6 (33.3)	18 (100.0)
Trader	5 (50.0)	3 (30.0)	2 (20.0)	10 (100.0)
CSW	-	-	13 (100)	13 (100.0)
Total		66 (19.2)		

Place of residence

Most respondents, 36.7%, stay in Khmer or mixed Khmer-Thai villages in the port area of Khlong Son/Khlong Makam, or, in Ban Suan Maprao in Khlong Yai sub-district. Many also stay in worker's houses provided by the employer as in the sawmills, 34.6%. Others stay on fishing boats, 18.3%, in the employer's house, 7.7%, and across the border in Koh Kong, 2.7%.

Of those who stay in worker's houses 31.6% are with families and the remainder are mostly single men. On the fishing boats they are all men and mostly single. Fishermen respondents are found in both fishing boats and in the Khmer or mixed villages, sea transport labourers are predominantly in these villages, as are fishery related employees, see Table 18.

Table 4.26 Place of Living by occupation

Place of Living	*F/man*	*F/relat*	*Sealab*	*S. mill*	*Agric.*	*S/maid*	*Trader*	*CSW*
Khmer	31.8	76.1	50.9	1.5	-	58.8	80.0	46.2
Worker house	12.1	21.7	23.6	89.6	81.0	11.8	10.0	7.7
Fishing boat	53.3	-	9.1	-	-	-	-	-
With employer	1.9	2.2	5.5	9.0	14.3	29.4	-	46.2
Koh Kong	0.9	-	10.9	-	4.8	-	10.0	-
Total %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 4.27 Place of Living by Marital Status

Place of living	*Single*		*Married*		*Divorce*		*Widow*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Khmer	42	26.4	75	46.3	2	50.0	5	45.0	124	36.9
Worker house	52	32.7	61	37.7	1	25.0	3	27.3	117	34.8
Fishing boat	48	30.2	12	7.4	1	25.0	-	-	60	17.9
With employer	13	8.2	11	6.8	-	-	2	18.2	26	7.7
Koh Kong	4	2.5	3	1.9	-	-	1	9.1	9	2.7
Total %	159	100	162	100	4	100	11	100	342	100

Period of time in Thailand

Length of stay can be relevant to having acquired Thai language, having acquired more knowledge on HIV/AIDS, but also it may mean increased exposure to risky situations. The demographic data demonstrates a correlation between those who have been in the area longer with moderate or high Thai language skills. A range of variables will be tested in the sections below on HIV/AIDS and risk situations.

There are no correlations with area or occupation. While Table 20 shows break downs of 6 months and 12 months, almost 14% of the total sample have been in the area less than four months, and a further 7% between four to eight months. This suggests that new people are regularly coming to Thailand. At the same time, with 22% having been in Thailand over four years many people are staying for long periods.

Table 4.28 Length of Stay by Area

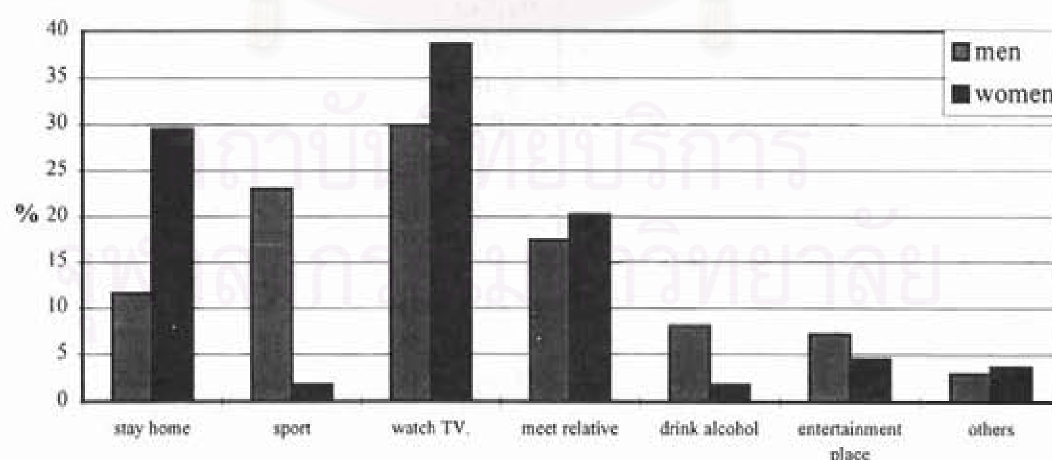
Period of time	Mai Rud	Khlong Yai	Had Lek	Total
≤ 6 months	6 (27.3)	27 (21.6)	33 (17.4)	66 (19.6)
7-12 months	1 (4.5)	21 (16.8)	38 (20.0)	60 (17.8)
1-2 years	4 (18.2)	18 (14.4)	42 (22.1)	64 (19.0)
2-4 years	8 (36.4)	29 (23.2)	36 (18.9)	73 (21.7)
>4 years	3 (13.6)	30 (24.0)	41 (21.6)	74 (22.0)
Total	22 (100.0)	125 (100.0)	190 (100.0)	337 (100.0)

Rest and Recreation

The first choice of recreation of most respondents was to watch television, 32.4%. the next three choices, in ascending order were: visiting relatives, staying home, and sport, 18.2%, 17.1%, and 16.2%, respectively.

Women were more likely to say that they watch television, stay at home, or visit relatives, in that order. Men's stated preferences were watching television, sport, meeting relatives, drinking alcohol, and entertainment. Fishermen were more likely to say entertainment or drinking than other groups. Those in the sawmill were the most likely to say sport, which may suggest that they are somewhat isolated and create their own sporting past-times.

Figure 4.12 Recreational Preferences by Gender



Watching television is predominantly mentioned by the younger age group, under 21, and those over 40 years of age. Staying at home is predominant among those over 40 years of age, 33.3%, with the under 21 years old the least likely to mention staying at home, 11%. Drinking alcohol was fairly evenly spread across age groups with the 21-30 year old group most likely to respond this way. Entertainment is mostly mentioned by those under 21, 8.2%, but is also mentioned by the 21-30 age group, 6.6%, and the 31-40 age group, 5.6%

In testing with other variables there is some correlation with speaking Thai in that those who have no Thai skills were more likely to say that they stay home, or that they watch television. Those with good speaking skills are the ones who were most likely to say that they visit relatives.

Table 4.28 Rest or Recreation Activities by Preference

Activity	First	Second	Third
Watching television	112	54	4
Staying at home	59	110	105
Meeting with relatives	63	39	9
Sport	56	14	8
Drinking	21	49	25
Entertainment	22	16	17
Other	11	2	5
Total	344	284	173

Community Activities

Of the total sample, 23.4% stated that they often participate in community activities, 38.7% said rarely, and the remaining 35.5% said they never participate in community activities. Such activities refer to temple activities which support the temple or celebrate festive occasions and religious holidays. Participation is similar between men and women. Traders are the most likely to participate in community activities along with maids/waitresses, others most likely to participate are sea transport labourers and fishermen.

Looking to the future

Training or study

Currently only 6.9%, or 24 respondents are doing extra-curricular training; however, many expressed a desire to have further training, primarily in general study and Thai language as shown in Table 4.29. The interest in Thai language perhaps reflects an interest or desire to stay in Thailand for some time.

Table 4.29 Respondents Interested in Further Training/study

Study interest	General study or training	Thai language	English language	Occupational skill
Yes	223 (65.6)	185 (53.5)	18 (5.2)	29 (8.4)
No	117 (34.4)	161 (46.5)	328 (94.8)	317 (91.6)
Total	346 (100.0)	346 (100.0)	346 (100.0)	346 (100.0)

Men had a greater interest in further training in all areas than women, although the proportions were very similar for Thai language. For English language no women were interested. Only three women were interested in occupational skills against 26, or 11% of all men, and it was mostly men who had been in the area for more than two years.

Plans to return to Cambodia

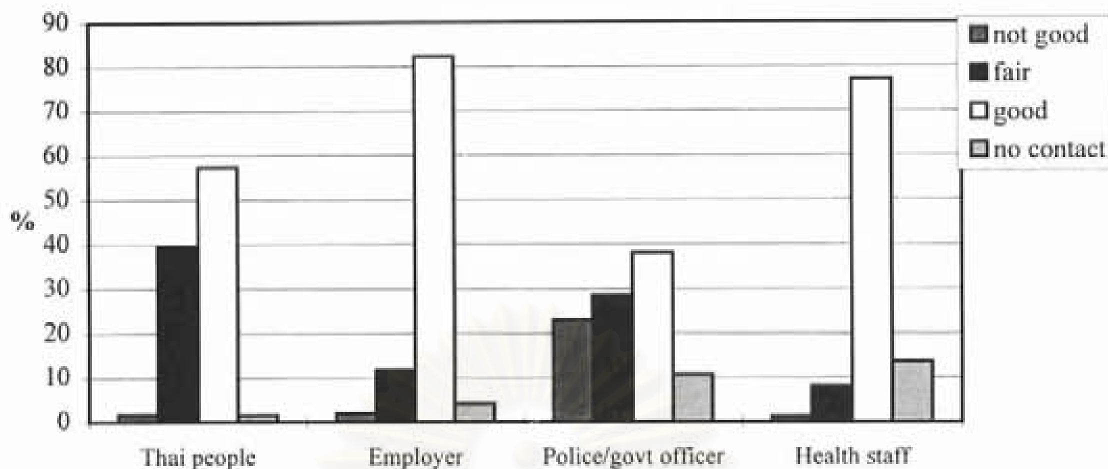
Over 80% said they planned to return to Cambodia, but for most respondents these are long term plans or their plans were uncertain. Less than one quarter of the total sample have plans to leave within twelve months. Men are more likely than women to want to return, 86% compared to 70.1%, and those between the ages of 31 to 40 years of age are the mostly likely to want to return, 89.1%, 21 to 30 year olds were the second most likely with 80.3%. There is little difference between single and married respondents. Those who have been in Thailand less than two years are much more likely to want to return than those who have been in Thailand over two years.

Attitudes to Thai People

Most migrants are disadvantaged through limited language skills and other factors in dealing with local Thais. They are vulnerable to exploitation and harassment and thus their experiences will influence their views on the people they deal with. It is important to have some understanding of local relations for difficult relations can certainly have an adverse impact on the lives of the migrants.

I t was not possible to explore Thai/Khmer relations much beyond the quantitative survey results reported here. These results may not capture underlying tensions to provide an accurate picture. Respondents were being interviewed by health officials and may not have wanted to express their true feelings. However, the findings here do seem to articulate some tension in relations, despite reportedly good relations, which may be a result of the historical background where many Thais previously lived in Koh Khong and are bilingual. The relationships of most concern are those with soldiers/police/border officials, which is to be expected given that many of these officials are authorised to seek out and detain any migrants suspected of being illegal. It would be advisable to explore this issue further when implementing HIV/AIDS programs.

Figure 4.13 Attitudes of respondents to Thai people



From the qualitative survey it appears that attitudes toward Thai people are generally good, and in the quantitative survey only six people, 1.7%, said that they are not good. However, 39.5% said that relations are fair, rather than good, which is what 57.3% said. Females were more likely to say that relations were good than males, 68.5% of all women compared to 52.1% of all men. Low education appears to be more predictive for having good relations, those with five years or less had proportions of 62%, compared to those with six years or higher having 51%.

Attitudes for health officials were positive, 77% of respondents suggested that they have good relations, with a greater percentage of women than men, 81.7% compared to 74.9%. A further 13.7% said they have no contact with health officials. Those with an income over B6,000 had significantly higher 'good' responses than other income cohorts. Those who had been in the area only a short time, less than six months, are less likely to report good relations.

Attitudes for Thai employers are even higher with 82.2% saying relations were good. There is little difference between men and women. Those with the lowest income, 90%, are more likely to report good relations, compared to all other income cohorts all very close to 76%. Those with an education of five years or less have proportions of 84.1% who stated that they had good relations with employers, compared to those with higher education 77.6%. Those working in saw mills and those working in sex work were the least likely to have good relations with their employers, 76.1% and 46.2%, respectively. Those working in the area four years or more are more likely to have good relations, 91.9%.

The situation is different, however, with attitudes toward soldiers and border officials/police, where only 38% said they have good relations, 28.4% said fair, and 22.9% claimed that they have poor relations with soldiers and border officials. A further 10.7% said that they have no contact with these officials. Women are more likely to say that they had good relations, 45%, compared to 34.7% of men.

In comparing Aranyaprathet with these findings from Trat there is very little difference in attitudes with the overall Thai population, but within categories there are differences. In Aranyaprathet it is less likely that they would have good relations with their employers. This may be due to the nature of the work being on a daily basis as daily commuters. Similarly with health officials, respondents in Aranyaprathet have less contact with health officials so they were less likely to say that they have good relations. It was only in regard to soldiers and police that Trat respondents were less likely to respond positively, and this can be due to the fact that there are many more workers who have crossed the border illegally, or have overstayed on their border passes.

Table 4.30 Attitudes of Respondents to Thai people

Attitude to	Gen. Population		Employer		Soldier/police		Health officer	
	Trat	Aran	Trat	Aran	Trat	Aran	Trat	Aran
Not good	1.7	3.1	2.0	5.2	22.9	17.2	1.2	0.7
Fair	39.5	34.5	11.7	20.8	28.4	29.3	8.1	7.2
Good	57.3	55.8	82.2	57.8	38.0	45.9	77.0	42.0
No contact	1.5	6.6	4.1	16.2	10.7	7.6	13.7	50.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Summary and Discussion

The respondents are drawn from three sub-districts of Khlong Yai District. Most of the respondents are from Had Lek sub-district where the immigration check point is and where most of the fishermen and Khmer communities are. In Khlong Yai sub-district there are fishermen but most of the respondents are from the sawmill. In Mai Rud sub-district there is a small sample of respondents working in agriculture.

In regard to the sample of respondents some industries were dominated by women – fishery processing, maids and other service work, traders, and sex workers. Only men were involved in fishing and it was mostly men working in sawmills.

In the age distribution of the sample men were predominant among the younger age groups, up to approximately 30 years of age, and women were predominant in the older age groups. Of the total sample 28.3% were under 21 years of age, and this only rose to 36.1% for those up to 30 years of age.

Women were over represented in the lower levels of education and under represented in the higher levels of education with a mean of 3.15 years compared to men with 5.72 years. Over half of all respondents, male and female, have five years or less of formal schooling.

Women comprise only 31.5% of the sample, which may reflect the actual proportions of migrants as there appear to be many single men, as well as married men living away from home. The proportions of married and single respondents are relatively equal. Over three quarters of single people are living in single accommodation, mostly fishermen or saw mill workers. Most respondents live in the Khmer or mixed Thai/Khmer villages, or, in employer provided housing. Some fishermen live on their boat.

Half the sample have someone they are in contact with in their hometown, and this is mostly parents so a large percentage send money to their parents. Of respondents remitting money home the amounts were considerably larger than in Aranyaprathet, with 50% sending more than B5,000 per year and some sending over B20,000. There were equal proportions of men and women and married and single who were sending money home.

Most respondents were being paid by the day and were earning between B60-B100 per day, although 34% were paid on a monthly basis and the remainder paid per job. Just over 40% of the sample estimated that they earned less than B2,000 per month with another 40% up to B4,000 and the remainder over B4,000. Traders had the highest income with a mean of almost B12,000 per month, sex workers had almost B6,000 and fishermen B4,000. Despite high earnings of female traders and relatively high earnings of sex workers men had higher earnings with a mean of B3,412 compared to B3,216.

Respondents were from many areas but most came from Kampot, Kampong Cham, Koh Kong, and Phnom Penh. Approximately a third the sample worked as farmers before migrating, with high numbers of students and unemployed; others included contract labourers, traders and fishermen. Most decided to migrate under the encouragement of friends or under their own initiative, with very few having agents or employers to support them. Over 40% said that they had some prior knowledge of the area before coming.

Over 60% of respondents never or rarely visit home, the remainder either visit once or twice a year, 22.3%, or more frequently, 13.6%. Men are more likely to visit than women, which is consistent with men being away from their families; and this includes equal proportions of both married and single men.

Almost 20% have only been in the area for six months or less. At the same time just over 20% have been in the area 2 - 4 years, and a similar proportion over four years. There were distinct correlations with 'length of stay' and an ability to speak Thai. Those who had been in the area more than two years had much higher proportions in moderate and high levels of proficiency in spoken Thai and in comprehension.

Recreation and future plans

Watching television was the most popular past time but predominantly for younger people and for women. Women and older people were also more likely to say that staying at home was their common past time. For men the common past times were watching TV, sport, and meeting with relatives. Almost a quarter of the sample said that they

participate in regular community events at the temple, and almost 40% said they do but rarely, the remainder do not participate.

Only 6.9% are currently undertaking some sort of study or training, and regarding future study, general study is the most favoured followed by Thai language and only a few wishing to study English or occupational skills. While 80% of respondents had plans to go back to Cambodia, less than 25% had plans to return within the next 12 months.

Attitudes to Thais

Only 1.7% of the total sample expressed negative attitudes to Thai people in general. There are very positive attitudes toward health officials and employers. Such positive attitudes were far less for police and border officials with almost a quarter of the sample claiming that they have poor relations with such officials. However, 38% did state that they have good relations. This is a very important issue and further qualitative research might tell us more about how good or bad relations are and how this can make migrant workers more insecure and more vulnerable.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Part III FINDINGS:

HIV/AIDS AND RISK SITUATIONS

4.7 Knowledge and Awareness of STDs/HIV/AIDS

This section covers the basic questions of 'ever heard of AIDS', 'ever heard of STDs', and tests knowledge of HIV/AIDS through a range of questions, which includes those of a general nature as well as those pertaining to transmission and prevention, the latter encompasses some common misconceptions. The **method of analysis** is as follows:

Five apsects of HIV/AIDS knowledge were chosen for systematic cross-tabulation, two are single questions (1 & 2 below), and three involved grouping questions together with the use of a scoring system (3, 4 & 5 below), which allowed for comparing means using Anova. The five areas are as follows:

General knowledge based on two major questions:

1 Can AIDS be cured?
2 Do HIV people have to have symptoms?
3 General knowledge based on nine minor questions:
Six questions on symptoms of AIDS, plus two on methods of testing for HIV
All grouped together to compare means and cross-tabulate with variables
4 Knowledge on transmission on 14 questions:
All questions on possible modes of transmission
All grouped together to compare means and cross-tabulate with variables
5 Knowledge on prevention on five questions:
All grouped together to compare means and cross-tabulate with variables

Demographic and migrant behavior variables were systematically cross-tabulated with the above five areas. The 'ever heard of STDs' question is treated as a major question also but is analyzed separately against the same variables. The 'ever heard of AIDS' question is not tested against the same range of variables, extensive analysis beyond frequencies is not necessary, thus only demographic variables were cross-tabulated.

Associations, statistical or otherwise, are reported for all demographic variables. Only a few of the variables pertaining to migrant behaviour proved to have significant or inferential correlations, they are as follows:

- Regularity of visiting home.
  - relatively equal numbers of those who visited regularly, occasionally, and never
- Stay with family or alone.
  - Most stay with their family, secondly with friends, and a smaller number alone
- Place of Living
  - Five divisions: on boat, in Khmer or mixed community, in worker's housing in Thai community (provided by employer), in employer's house, in Koh Kong
- Ability for spoken Thai - Four divisions: no skills, low, moderate, high

For the remaining sections a range of relevant variables were tested in order to describe and analyse the situation of vulnerability for migrant workers, and for seeking solutions and strategies. These sections include commercial sex, condom use, high risk practices and beliefs, self-reported risk behavior, drug use, acceptable norms of sexual behavior, and attitudes to people living with HIV/AIDS. A range of variables relevant to each context were selected and tested.

In the section below on STDs, correlations are analysed for statistical significance or inferential correlations. Variables that are cross-tabulated are explained clearly in the STD section and appear in specific sequence in order to establish the model of presentation for the following sections on knowledge, transmission and prevention.

Ever Heard of AIDS: through what means

Most people have heard of AIDS before coming to work in the border region, 72%. A similar proportion, 75.8%, have heard of AIDS while in Thailand. When both questions, 'did you hear of AIDS in Cambodia' and 'did you hear about AIDS in Thailand', were cross-tabulated it revealed that 10.5%, or 36 respondents have not heard of AIDS.

In asking what are the main sources for hearing about HIV/AIDS most people cited TV and radio; however, this is closely followed by 'through talking with friends' (see Table 4.31). Respondents were asked to make multiple responses if there were more than one source. There is little variation in the sources cited between hearing about AIDS in Thailand or Cambodia. TV and radio are slightly less in Thailand, reflecting less access given the basic living conditions that many migrants experience, and of course the language barrier. Newspapers and magazines plus posters are also mentioned less for Thailand, which again may reflect language difficulties.

Table 4.31 Sources for Hearing about HIV/AIDS: Cambodia and Thailand
(multiple responses)

Through what means	In Cambodia N=249	In Thailand N=260
Talking with friends	39.9	43.7
TV or radio	50.7	44.3
Newspaper/magazine	24.6	19.2
Poster	10.8	7.6
Government officer	14.9	14.6
NGO	5.3	1.2
School teacher	3.8	0.3

Cross-tabulations of 'ever heard of AIDS in Thailand' with gender and education presented no unusual findings. Those with a lower education are less likely to use newspapers, or gain information from TV and radio; however, those with no formal education and I-5 years, are more likely to gain information through talking with friends

(see Table 4.32). Women are more likely than men to gain information through talking with friends. This is an important finding in that it indicates peer education may be an important strategy, particularly in this situation where literacy is low, and thus written media is of very limited use.

Table 4.32 Main Sources for Hearing about HIV/AIDS by Education

Heard from where	None	1-5 years	6-9 years	>9 years	Total
Talking with friends	52.5	50.8	35.8	29.4	43.7
TV or radio	31.1	43.0	52.5	44.1	44.3

Men are much more likely to have heard of AIDS, while in Thailand, than women. There is little difference between married and single people. There are significant correlations with length of stay in Thailand with 89.2% of those being in Thailand over four years compared with 61.5% of those who have been in Thailand six months or less. Traders, sea transport labourers, farmers, and fishermen, in that order, all have over 80% who have heard of AIDS in Thailand.

Ever Heard of STDs: comparing variables – demographics and migrant experience.

Over 40% claimed to have never heard of STDs, a similar figure to Aranyaprathet. If this figure is accurate it reflects some concern as STDs remain a serious problem in Cambodia, just across the border in Thailand the problem has reduced but the situation of HIV and of STDs, where resistant strains are common, is serious cause for concern.

There is a significant relationship between the variables of education and ever heard of STDs, 60% of those with no formal education are the least likely to have heard of STDs, those with an education between 6-9 years have the lowest proportions, 32.5%.

Table 4.33 Ever Heard of STDs by Education

		None	1-5 years	6-9 years	>9 years	Total
Have you ever	No	60.0	42.4	32.5	38.2	41.6
Heard of STDs	Yes	40.0	57.6	67.5	61.8	58.4
Total		100.0	100.0	100.0	100.0	100.0

The only correlation that can be drawn for different age cohorts is between those under 21 years and older categories, the proportion aware of STDs under 21 is 47.1% compared to the other age cohorts in ascending order, 63.3%, 56.4%, and 57.1%. Cross tabulations with marital status show that married people are only slightly more likely to have heard of STDs than single people, which is consistent with most younger people not having heard of STDs and not being married.

There is a significant relationship between men and women, with 65.9% of all men having heard of STDs compared to 42.5% of all women. Those who have little or no Thai speaking skills have distinctly lower rates of correct responses than those with moderate or high skills.

Fishermen and traders are more likely to have heard of STDs than other workers, 67.9% and 70%, respectively. While there is no statistical significant relationship here such a finding corresponds to area, in HL, where most traders and fishermen come from, 63.1% have heard of STDs, compared to KY and MR which have proportions of 53.2% and 47.6%, respectively. This in turn corresponds to income where there is a significant relationship with only 44.1% of those earning under B2,000 being aware of STDs, compared to 68.5% of those earning over B2,000.

Figure 4.14 Ever Heard of STDs by Area
Ever Heard of STDs by Income

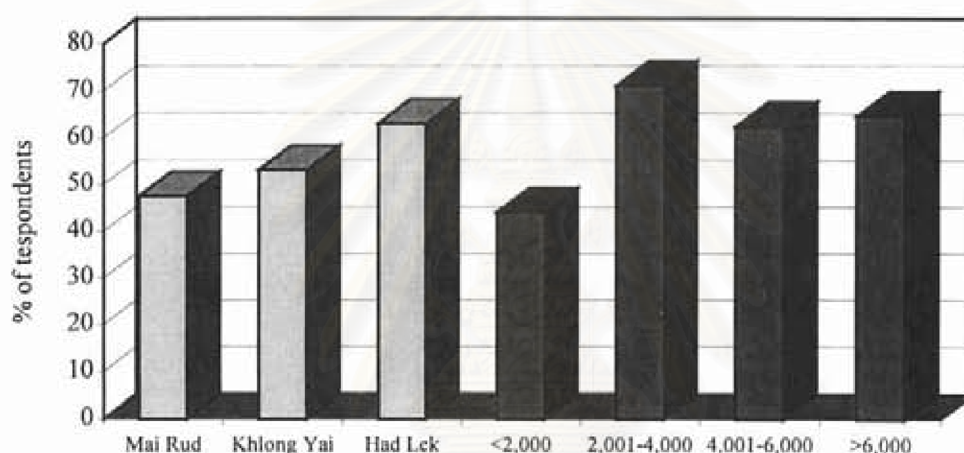
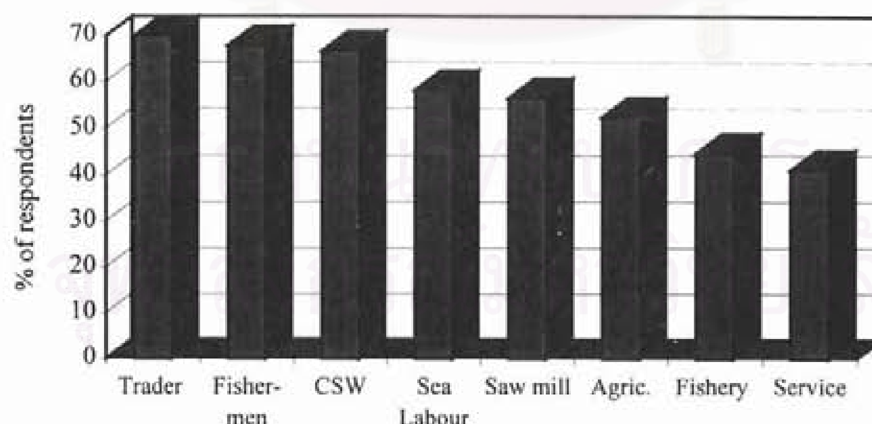
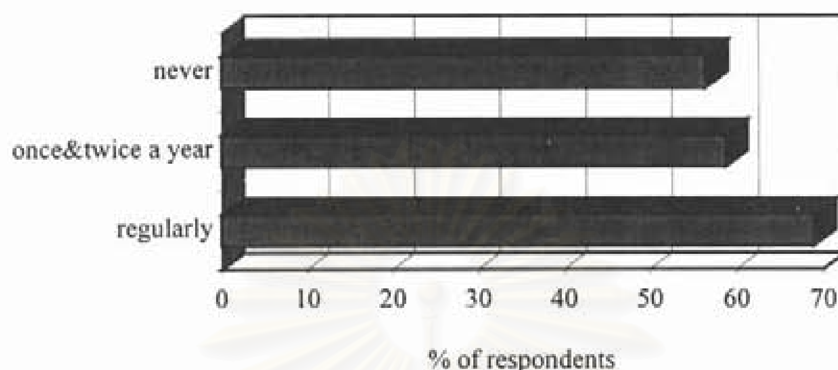


Figure 4.15 Ever Heard of STDs by Occupation



Those respondents who regularly visit home are more likely to have heard of STDs, 68.9% of the sample who return regularly, as opposed to 58.7% who visit once or twice a year, and 56.4% with those who do not visit, or rarely visit, home.

Figure 4.16 Respondents Heard of STDs by Frequency of Visiting Home



Of respondents who live alone, 74.1%, have heard of STDs; of respondents who stay with friends 61.2% have heard of STDs, and of those who live with their family 50.4% have heard of STDs. Males predominate in the first two categories and females in the third indicating that these findings reflect the lack of awareness among females.

Those who stayed on the boat are the most likely to have heard of STDs, 70.7%, followed by those who stay in worker's houses which are in the Thai community, 65.2%. Those in Khmer or mixed villages, and those living within the employer's home have lower rates.

General Knowledge of HIV/AIDS: cure/symptoms/testing

General knowledge, as described above, utilises two single questions, and then a group of eight minor questions, which are in effect given the same weighting as the first two questions. These are then treated as three questions, as described above and elaborated on here, which test different aspects of HIV/AIDS knowledge, as follows:

1 Can AIDS be cured?
2 A person who is HIV positive may not necessarily have any symptoms?
3 What are the symptoms for HIV infection, and the testing methods for HIV detection.

   Six symptoms were given, one at a time, yes/no/not sure, and responses were recorded. Two testing methods for detecting HIV were given – testing by blood, and testing by urine. The agree/not agree/not sure responses were recorded.

Questions in item 3 were given scores of 1 for all correct answers and the means was determined for comparing through Anova.

1 Can AIDS be cured

Most people understand that AIDS cannot be cured; however, given that 18.5% think that it can be cured, and 22.5% did not know, demonstrates that many people are still not clear on the threat of HIV/AIDS.

There is no significant relationship with age, the oldest age group have the highest proportion of correct responses, 71.4%. Single people are more likely than married people to respond correctly, 62.3% opposed to 54.5%. Men have a significantly higher proportion than women.

There is no significant correlation with education; however, there is a gradual increase from the no formal education cohort, 54.1%, through to those with over 9 years of schooling, 64.7%.

Those working on farms, in agriculture, are the most likely to have correct responses, there is little difference between other groups except for low proportions among service/maids and CSWs. This is consistent with MR having the highest proportion of correct responses, 72.7%. There is no significant relation with income; however, respondents earning less than B2,000 are less likely to have correct responses than those with over B2,000, 52.7% compared to 61.8%. The highest income brackets; however, have low proportions as shown in Figure 4.17.

Figure 4.17 Correct Responses to 'Can AIDS be cured' by Occupation

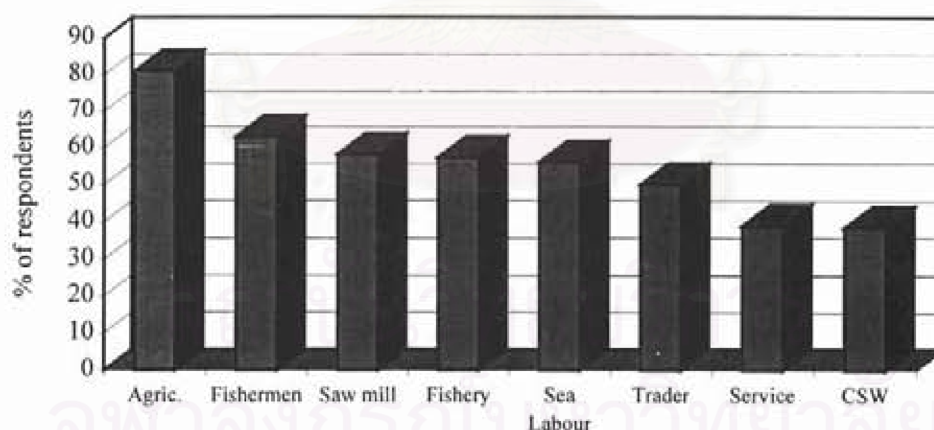
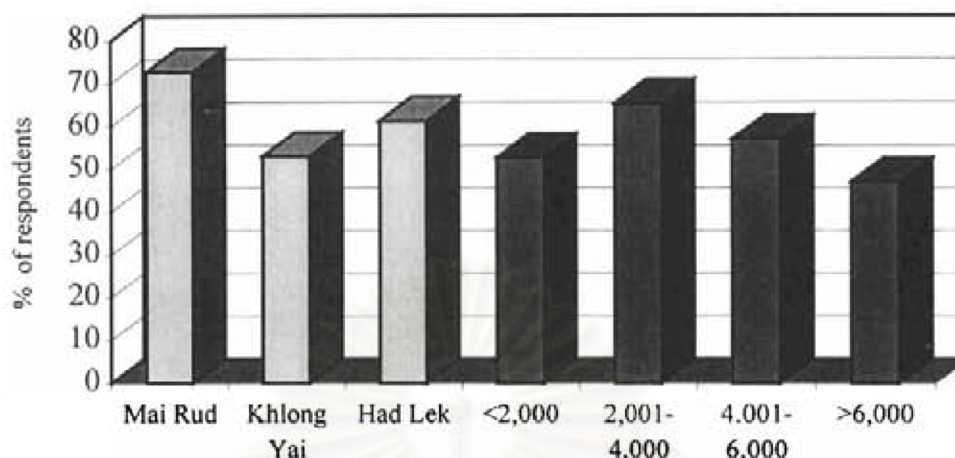
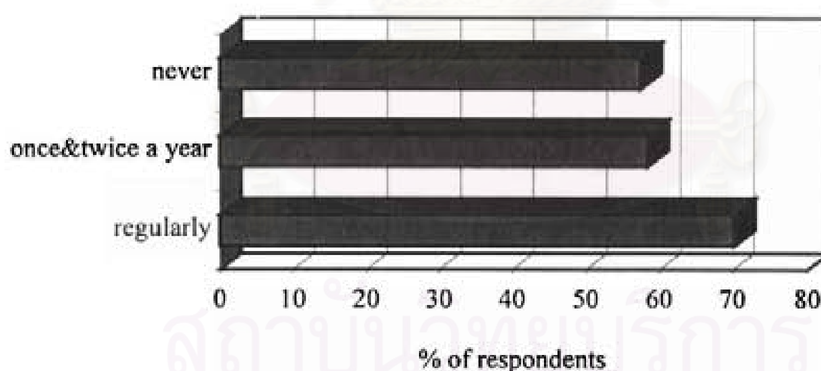


Figure 4.18 Correct Responses to 'Can AIDS can be cured' by Income
Correct Responses to 'Can AIDS can be cured' by Area



There is no correlation with Thai speaking ability, in fact those with no skills are likely to have higher responses. Those who regularly visit home have higher rates of correct responses, 70.2%, than those who visit occasionally or never visit, and the latter have more don't know/not sure responses.

Figure 4.19 Respondents Heard of STDs by Frequency of Visiting Home



Those who stay alone have the highest proportion of correct responses, 65.5%, compared to staying with friends and with family. Most respondents with correct responses are staying in Khmer or mixed village communities.

2 Do HIV positive people necessarily have symptoms

Over 50% of respondents could not answer the question regarding whether HIV positive people have to have symptoms. Only 28.3% of the total sample answered correctly. This indicates that people do not have sufficient understanding to distinguish between HIV and AIDS. This distinction is important for understanding that HIV positive people can live healthy, normal lives for several years, which in turn has implications for understanding the spread of HIV as well living with people with HIV or AIDS.

The proportion of married people with correct responses is higher than single people, 32.3% compared to 24.7%. With regard to gender, 33.3% of all males answered correctly compared to 17.4% of women, and women have far more don't know/not sure responses. Those with five years of schooling or less are less likely to respond correctly than those with a higher education but it is not significant (see Table 4.34). There is no correlation between low literacy in Thai language and higher literacy.

Table 4.34 Do HIV+ People have to have Symptoms, by Education,

Education level		None	1-5 yrs.	6-9 yrs.	>9 yrs.	Total
HIV+ person must have symptoms?	No	14.8	14.8	13.0	23.5	15.0
	Yes	23.0	25.8	32.5	32.4	28.3
	Not sure	62.3	59.4	54.5	44.1	56.6
	Total	100.0	100.0	100.0	100.0	100.0

There is no correlation with occupation, fishermen and farmers have slightly higher proportions than other groups. Similarly, there is no correlation with Area. There is some correlation with income, those earning over B2,000 have the higher proportion of correct responses, 33.3%, compared to those below B2,000 with 23.7%, with the latter also having higher don't know/not sure responses.

Figure 4.20 Do HIV+ People have to have Symptoms by Occupation

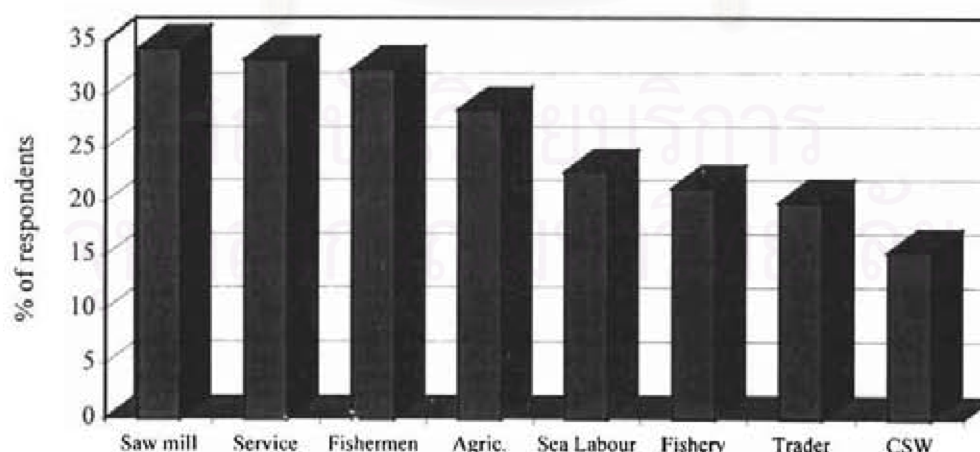
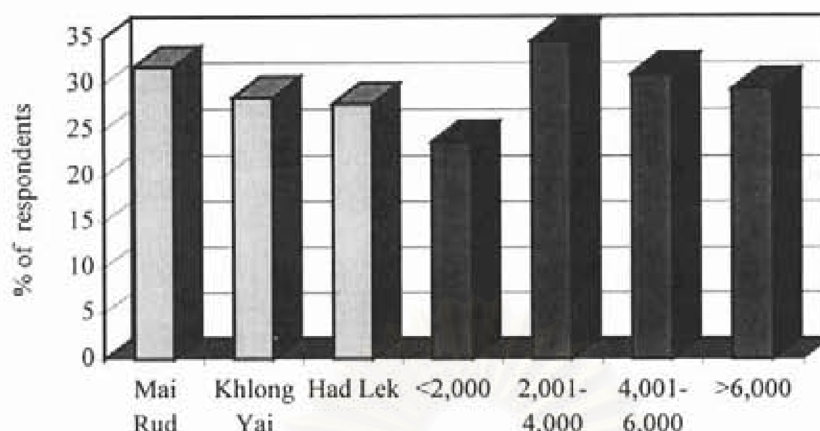


Figure 4.21 Do HIV+ People have to have Symptoms by Area
Do HIV+ People have to have Symptoms by Income



There are no differences in the proportions of regular, non-regular, and never visiting. Regarding the question 'whom do you stay with' there are limited correlations. Those who stay with friends are more likely to respond correctly with a proportion of 30.4%. Those who stayed with families are 26.4%, and those who stay alone are 17.2%. This finding of people staying with friends is consistent with the high proportion of respondents staying in the Thai work residences, or on fishing boats, 39.3% and 30.6%, respectively.

3 Symptoms of HIV/AIDS and testing methods for HIV

On the symptoms of HIV/AIDS, taken on an average of correct response for all six questions, 60.9% of respondents could answer correctly when asked if a specific symptom was associated with HIV/AIDS. On the testing methods for HIV 20.8% said that urine a valid and common test for HIV, which is incorrect, and 65.6% are not sure, which is probably a valid response for a difficult question. In regard to blood testing 75.7% responded correctly that it is a proper method for detecting the presence of HIV, 2.6% said no, and the remaining 24.3% did not know/ are not sure.

In comparing the tabulated means for all questions in #3 with education there is no significant correlation; however, those with no formal education and those with five years of schooling or less have distinctly low proportions of correct responses.

Males have significantly higher response rates than females, and single people are more likely to respond correctly than married people. The oldest age group and the youngest age group have the lowest proportions of correct responses.

Those with the lowest income have the lowest proportion of correct responses, and there is a significant correlation with the income cohort of B4,000 to B6,000. Those on B2,000 to B4,000 are in-between. However, those above B6,000 have similar low rates to those below B2,000. Employees in the male dominated industries, that is, fishing, wood mill,

and agriculture, are most likely to respond correctly. There is no difference between the three sub-districts.

Among the cohorts with varying abilities for spoken Thai those respondents with moderate skills have the highest rates and this is significant against those with no skills. Those with high skills also have high rates of correct responses and those with low skills have relatively low rates.

Respondents who visited home regularly are only slightly more likely to respond correctly than those who did not. There is no significant correlation with those who stay with families and others, however, those who stay with families are more likely to respond correctly and those who stay alone are most likely to have incorrect responses. Those staying with friends is in-between these two. Those respondents who live within the Thai community in worker's houses have significantly highest rates of correct responses than those who stayed in housing provided by the employer, and those on boats and in the Khmer and mixed villages are in-between.

Knowledge of Transmission

Being able to articulate the transmission routes of HIV/AIDS indicates an understanding of how HIV is spread; however, often it is misleading as people can recall from the media the main forms of transmission without necessarily having a clear understanding of modes of transmission and how HIV actually spreads through the population. And despite knowing the main forms of transmission people may still be confused about casual contact and transmission of HIV.

The findings here suggest that there are still misunderstandings regarding the casual transmission of HIV. Such misunderstandings may be perceived as logical conclusions, or assumptions that people make. They draw these conclusions from their knowledge of communicable diseases, and from some traditional beliefs, and in tandem such understandings can arouse fear. These misconceptions were once common in Thailand and have occurred throughout the world. Such misunderstandings must be challenged if fear, leading to stigma and rejection of people with HIV/AIDS, is to be reduced.

While the data here is much more promising than the data from Aranyaprathet, Table 4.35 indicates that substantial numbers still have misconceptions in how HIV spreads. Moreover, we cannot always take at face value what people say, for instance, if many people have been exposed to some education they may be repeating what they have heard but have not really internalised their feelings or awareness, especially in regard to how HIV is not transmitted casually. There is some evidence for this in the findings in the section on attitudes to PWHA. While there are far fewer incorrect answers than inAranyaprathet, by at least 20 points for most questions, there are more don't know/not sure responses in Trat, approximately 15 points different.

Most questions in Table 4.35 pertain to living and sharing with family members or others, and less than a quarter of respondents agreed with the questions on whether HIV could be

transmitted in these way, thus most respondents are correct in not agreeing. Other questions pertain to contaminated blood with intact skin, and mosquitoes transmitting HIV, both of which also contain no risk. Kissing is included here for it also does not transmit HIV. Even though an exchange of saliva may occur through deep kissing it is very unlikely to transmit HIV

Table 4.35 Misconceptions in the Transmission of HIV

Possible modes of HIV transmission	Agree	Disagree	Don't know	Total
Touching	16.5	62.1	21.4	100.0
Sharing glasses	20.8	57.2	22.0	100.0
Sharing toilet	23.7	48.6	27.7	100.0
Sharing clothes	23.4	49.1	27.5	100.0
Blood with intact skin	36.7	30.6	32.7	100.0
Kissing/saliva	24.0	29.8	46.2	100.0
From mosquitoes	52.3	52.3	25.4	100.0

While the findings on casual contact and how HIV is *not* transmitted is more positive for Trat respondents findings on how HIV *is* transmitted suggest that there is an inconsistent and limited understanding. Most respondents could identify heterosexual sex and sharing needles as the main modes of transmission, along with receiving blood, as in blood transfusions. However, these are markedly lower than the proportions of respondents in Aranyaprathet. Only a small proportion of respondents could identify homosexual sex and anal sex as risky behaviours, this is up to 40 percentage points below the percentages in Aranyaprathet, and the don't know responses are particularly high. Unprotected anal penetrative sex is certainly very risky and should be recognised as such.

In regard to other risk situations, which generally contain far less risk, respondents in Aranyaprathet have comparatively high percentages suggesting that HIV is transmitted in these ways. For example, sharing razors contains minimal risk, the risk is increased if used soon after being contaminated but it still has to come into contact with blood from broken skin on the next person using the razor. Oral sex can certainly be of some risk if there are lesions in the mouth that allows seminal fluid to contact blood, but it is of a much lower order than the other practices mentioned above and presented in Table 4.36. Thus, while respondents in Trat have far lower correct responses it is understandable that they should not be clear on these transmission routes, and in fact over 60% are correct in suggesting that sharing razors is a transmission route for HIV.

Table 4.36 Knowledge of HIV Transmission

Possible modes of HIV transmission	Agree	Disagree	Don't know	Total
Male-female sex	77.7	2.6	19.7	100.0
Sharing needles	73.4	3.5	23.1	100.0
Receiving blood	70.8	5.2	24.0	100.0
Anal sex	30.9	7.2	61.8	100.0
Male-male sex	31.8	31.8	58.7	100.0
Oral sex	31.2	12.4	56.4	100.0
Sharing razor	60.4	6.4	33.2	100.0

In order to analyse these findings in terms of demographics and migrant behaviour a score of 1 was given for each correct response on all modes of transmission. Means was then tabulated through Anova to determine significance of several variables with the knowledge on modes of transmission.

There is no significant correlation between age cohorts, although those over 40 years old have much lower proportions of correct responses. Men have significantly higher awareness than women, and single respondents have significantly higher awareness than married respondents. There is a significant correlation among those with no formal education and those with five years or less of schooling compared with all those with a higher education.

There is statistical significance between the low income cohort below B2,000 compared to the cohort B2,000 to B4,000, and B4,000 to B6,000, however, as with #3 in general knowledge the above B6,000 cohort have low proportions of correct responses, closer to that of the below B2,000 cohort. Fishermen are more likely to have correct responses than any other occupational groups, significantly higher than some occupations. Those working in agriculture are the only other group to achieve high proportions of correct responses.

There is no significant correlation between different levels of ability in spoken Thai, however, those with no skills have distinctly lower rates of correct responses than those with skills. Those respondents who return home regularly have higher but not significantly higher proportions of correct responses than those who visit occasionally and those who never visit.

Those respondents who stay with friends have significantly higher proportions with correct responses than those who stay with families, and those who stay alone have relatively low rates as well. Those who stay on boats and those who stay in Thai workers houses have significantly higher correct responses than those staying in the owner-provided residences, and those staying in Khmer or mixed villages have low rates of correct responses as well.

Understanding of Prevention

A number of common myths in the prevention of HIV are explored in the questions in this section. The first question was on the effectiveness of condom use, which was not so much in the category of misconceptions as the other four questions. While 75.4% responded that condoms can prevent HIV infection 7.5% said that condoms do not offer protection, and 17.1% are unsure/don't know, which suggests some concern given the high prevalence of sex work. The first real myth however, is in regard to the question of whether choosing a healthy and clean looking person to have sex with offers some protection. It is of concern that 24.3% of respondents suggest that selecting such women (mainly pertaining to sex workers) does offer protection, with 37.9% not sure. Negative and affirmative responses to whether condoms are necessary with partners who were not sex workers are almost identical, 35.3% and 34.4% respectively, and 30.3% are not sure. Another myth is that if a man uses the withdrawal method before orgasm infection will not take place; 18.5% agreed with this and 58.1% are unsure, leaving only 23.4% rejecting this theory.

Another question exploring myths and beliefs was the question regarding the drinking of alcohol before and after sex to prevent AIDS. Only 12.2% agreed, and 49.3% are unsure, leaving 38.5% disagreeing that this practice has any validity. The final myth, which has been common in the past among some sex workers, is that HIV testing every three months offers some protection from infection. Almost half, 46.8%, are unsure or did not know on this question and 35.8% agreed that testing could offer protection, thus only 17.3% rejected this idea.

Thus, all but the first question on condom use are myths regarding the prevention of HIV, and therefore, as presented in Table 4.37 correct responses are those that agree with the first question but disagree with all the others.

Table 4.37 Prevention Practices and Misconceptions

Practices and beliefs that are protective against HIV	Yes	No	Don't know	Total
Using condoms	75.4	7.5	17.1	100.0
Selecting healthy looking person	37.9	24.3	37.9	100.0
Sex with person who is not CSW	35.3	34.4	30.3	100.0
Withdrawal before ejection	18.5	23.4	58.1	100.0
Alcohol before and after sex	12.2	38.5	49.3	100.0
Regular blood tests for HIV	17.3	35.8	46.8	100.0

To analyse correlations with knowledge and other variables scores were given as with transmission and then the means of responses was compared using ANOVA.

Men have statistically significant higher scores than women. Single respondents have higher scores than married respondents. Educational levels are significant for those with no formal education and those with 1-5 years compared with higher educational cohorts.

The over 40 year old cohort have the lowest rates of correct responses and those under 21 years old have the next lowest but there is no significant correlation.

Again, fishermen have the highest proportion of correct responses followed by those working in agriculture. There is a statistical significance between those with earnings below B2,000 and those with over B2,000.

There is no significant relationship among the levels of spoken Thai ability, however, those with no skills have distinctly lower rates than others.

Among respondents who visited home regularly there are higher proportions of correct responses than those who never visit or occasionally visit, although there is not a significant correlation. There is little difference in the responses of those who stayed with families and those who did not.

Those respondents who stay with friends have significantly higher proportions with correct responses than those who stay with families, and those who stay alone have slightly low proportions than those with friends. Those who stay on boats and those who stay in Thai worker's houses have higher correct responses than others, with the former significantly higher than those staying in Khmer or mixed villages.

Discussion and summary

This section tests whether respondents have heard of STDs and HIV/AIDS and then seeks to determine the level of knowledge of HIV/AIDS. As a large proportion of the sample are illiterate, or have low literacy in Khmer, and have very little or no Thai language, their access to knowledge and understanding of HIV/AIDS is limited. Most people gained knowledge through talking to friends or from television and radio.

The five areas of knowledge have been tested against demographic and migrant behaviour variables and are summarised below.

Women are definitely disadvantaged in having less knowledge than men, this may be due to access to materials and low literacy rates among women. Single people scored higher than married respondents in four out of five areas, only failing to reach the same proportions on the question of whether HIV positive people have to have symptoms. Over 40 year olds and under 21 year olds have distinctly lower rates of correct responses than other age groups.

Low education, such as those with no formal education and those with five years or less, compared with the higher education cohorts demonstrated a correlation with low HIV/AIDS knowledge. From no education to the highest education there is generally an incremental rise of proportions of correct responses, and with two of the five areas there is a statistically significant correlation. Some correlations could be drawn with Thai

language in the three of the five areas, mainly with respondents who have no Thai speaking skills having low proportions of correct answers.

Correlations with income could be drawn in all five areas with some variation. In two areas there is the incremental rise in proportions of correct responses with increasing income, as observed in other areas, with the proportion falling with the highest income, over B6,000. This may be attributable to the smaller numbers in that category. Income is shown to be statistically significant in one area. Fishermen are consistently more likely to have correct responses than other occupational groups. Those working in agriculture often have high proportions also but the sample size is much smaller.

Four migrant behaviour variables demonstrated correlations, however, there are no significant correlations and they are less pronounced than in Aranyaprathet. Two of these variables also demonstrated correlations in Aranyaprathet. The first is in relation to those who regularly visit home, where in four of the five areas of knowledge tested they are more likely to have correct responses compared to those who never visit, or occasionally visit. The bivariate analysis showed distinct correlations but there are no significant correlations.

The second variable that showed correlations in both sites is with the living situation of respondents. Those respondents who live with friends, rather than family or alone, are only slightly more likely to have more correct responses. While the correlation here is not strong it is supported by the third variable - living situation, or, place of residence. Those living on boats, and those living in worker's houses are the most likely to have correct responses, which corresponds with fishermen living on boats with friends and those who live with friends in employer provided housing.

The final variable is the ability to speak Thai. This showed distinct correlations on three of the five areas, but with no significant correlations.

The most distinct findings here are that the knowledge and general awareness is low, and the low rates of literacy make this a cause for concern. Correlations of low awareness with women, young people, low income, and low education, highlight issues of vulnerability among migrant groups. This is similar to the findings in Aranyaprathet, and is highly suggestive of migrants not being prepared for living in an environment of high risk.

Migrants live in an environment where Thai people often own residences, and factories, and fishing boats where migrants live and work. With most business dealings and health concerns they have to deal with Thais, and most have little or no language skills. Many are illegal in Thailand and may be in fear of being caught or harassed by officials. They are in a position of powerlessness in many ways, which can make their situation highly insecure. Many live in enclaves as a way of coping and thus minimise their dealings with Thais outside. However, this may mean that they are difficult to reach and do not readily receive health messages or other helpful information, and they do not increase their Thai

language skills. CARE's recently implemented program should go some way to changing this situation.

In Trat there has been an effort to educate migrants on HIV/AIDS over the past five years, but if our survey results are a measure of the impact of this work on the migrant's HIV/AIDS awareness the findings are mixed at best. Awareness is still low in most areas and one practical way to measure this is to compare the findings with those of Aranyaprathet, which we have been doing throughout the above discussion. The findings do not readily lend themselves to clear anyalysis when comparing the two sites, however, there are consistent patterns that can be discussed. Respondents in Aranyaprathet have a much greater awareness of high risk transmission practices than respondents in Trat. This is shown in Table 4.38, with the only qualification being that oral sex and sharing of razors are not necessarily high risk; however, the question posed was pertaining to whether respondents agreed with these being transmission routes for HIV, and so respondents in Aranyaprathet have more correct responses. The situation is reversed for casual contact and behaviours that do not contain risk where fewer Trat respondents agreed that such practices are risky. Thus, demonstrating a greater awareness than those in Aranyaprathet.

Given that only small proportions of Trat respondents thought that HIV could be transmitted through casual contact suggests that they have better attitudes regarding living with PWHA. While this awareness is reflected in some attitudes toward PWHAs it is contradicted in other attitudes (see discussion on Attitudes to PWHA).

Table 4.39 Responses Agreeing to Possible Modes of HIV Transmission
Comparison Aranyaprathet and Trat

Possible modes of HIV transmission	% Agree	
	Trat	Arran
Male-female sex	77.7	90.0
Sharing needles	73.4	90.9
Receiving blood	70.8	87.2
Anal sex	30.9	69.8
Male-male sex	31.8	59.1
Oral sex	31.2	59.0
Sharing razor	60.4	84.9

Table 4.40 Responses Agreeing to Misconceptions on HIV Transmission
Comparison Aranyaprathet and Trat

Possible modes of HIV transmission	% Agree	
	Trat	Arran
Touching	16.5	34.8
Sharing glasses	20.8	42.8
Sharing clothes	23.4	40.9
Sharing toilet	23.7	45.6
Blood with intact skin	36.7	65.5
Kissing/saliva	24.0	55.3
From mosquitoes	52.3	70.5

Trat respondents have slightly lower rates of correct responses on general knowledge, only noticeable on the question of what are common symptoms for AIDS. Regarding prevention, on four question there is minimal variation but Trat respondents did much better on the last two, namely, 'withdrawal before orgasm can be protective against AIDS' and 'having three monthly tests for HIV may be protective', where they are far less likely to agree. It is only with the first question on condoms as protection against HIV that to agree is the correct response.

Table 4.41 Prevention, Practices and Misconceptions
Responses agreeing with such practices – Trat andAranyaprathet

Practices and beliefs that protect against HIV	Trat	Arran
Using condoms	75.4	71.9
Selecting healthy looking person	37.9	33.2
Sex with person who is not CSW	35.3	41.3
Alcohol before and after sex	12.2	17.2
Withdrawal before ejection	18.5	34.9
Regular blood testing for HIV	17.3	49.2

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Summary of overall knowledge through ANOVA

In addition to the analysis above one-way ANOVA was used to calculate overall knowledge according to occupation (Table 4.38). This involves collapsing the three general knowledge sections plus one section on transmission and one on prevention knowledge into one overall knowledge section. The mean knowledge score of all respondents is .4489 out of a score 1.0, which is lower than that of Aranyaprathet which is .5357. This overall score may be misleading for while knowledge on transmission was very good misconceptions were high in Aranyaprathet, as is explained in the summary above. Consistent with the findings discussed above men had the highest knowledge with fisherman having the highest means, followed by agriculture, sawmill employees, sea transport labour. All the other occupations are in female dominated industries.

Table 4.38 ANOVA Compare Means of all Areas of Knowledge by Occupation

Occupation	Number	Mean	Standard Deviation
Fishing	111	.5066	.1668
Fishery related	47	.3555	.2190
Sea Transport labour	57	.4555	.2180
Sawmill	67	.4603	.2228
Agriculture	21	.4787	.1858
Service/maid	18	.3439	.2373
Trader	10	.4149	.2508
Sex worker	13	.3042	.2148
Total	346	.4489	.2107

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4.8 Attitudes and Beliefs on Sexual Behavior

Masculine behaviours: attitudes and acceptability

There were five questions referring to potentially very high risk behaviours which are related to masculine prowess and misconceptions. The beliefs and practices explored here can lead to revealing a hard core group of people who continue to practice very high risk behaviors. The questions are designed to identify respondents who agree that such practices are acceptable. For a summary of the significance of these practices, and the possible consequences, see this section in the Aranyaprathet report.

The first of the five questions refers to what in Thailand is known as *kheun kru* where young men may be initiated into sex through sexually experienced women such as sex workers. Other questions were dealing more specifically with myths or misconceptions such as the non-use of condoms being associated with masculine bravado; drinking alcohol as a means to increase sexual stamina and virility; and the use of marble implants in the penis or the use of oil injections for increasing penis size in order to enhance stimulation for their partner.

Kheun khru has been a common practice in Thailand but reportedly has reduced in significance due to the AIDS epidemic. While it may not be a traditional practice in Cambodia it is reported that many young men have their first sexual experience with a sex worker (Tarr 1997). The use of injections and implants has also been relatively common among some groups in Thailand but has apparently reduced in recent years. It appears that it may still occur among some fishermen and some other places where men live and work together. It has been documented among Thai and Burmese on the Myanmar border in recent years (see report on Myanmar).

Table 4.42 Respondents Agreeing with High Risk Beliefs and Practices

Practices and beliefs	Men		Women		Total	
	No.	%	No.	%	No.	%
Kheun khru	131	(55.7)	22	(20.8)	153	(44.9)
Condoms and bravado	115	(48.9)	30	(28.0)	145	(42.4)
Implants and injections	23	(9.9)	3	(2.9)	26	(7.7)
Alcohol and virility	79	(33.8)	9	(8.4)	88	(25.4)

Men are more likely to agree with these practices than women by a factor of between four and ten times. Correlations with education are not clear except for over nine years of schooling and only for two categories, which contrasts with Aranyaprathet. Income correlations are quite clear and it was clear that fishermen are the most likely to agree with these practices. The don't know/not sure responses were all over 40% except for the question on condom use and male bravado which was only 24.6%. Over 60% responded

with don't know/not sure on the question of marble implants and injections to increase the size of the male organ, which may reflect ignorance of this practice on behalf of most people. Each of the questions is discussed separately, below, followed by tables.

Of the 153 people who agreed with the practice of *kheun khru,* the higher proportions are among fishermen and those from the sawmill, with a low rate of responses from sex workers. There is a correlation with higher income and with over nine years of schooling.

Of the 145 who agreed with the ideas associated with condoms and male bravado, again fishermen and sawmill employees had the highest proportions but sex workers also had high proportions agreeing. Correlations with income were less than those above, primarily the difference was between those earning below B2,000 and those earning above B4,000. There was a correlation with over nine years of schooling.

Of the 26 respondents who agreed with the ideas associated with marble implants and injections, fishermen had relatively high proportions. The only other correlation was with income where low income earners had low proportions.

On the question of alcohol increasing sexual stamina and virility, where 88 respondents agreed, again fishermen are most likely to agree but there are also high proportions among sawmillers, farmers, labourers, and sex workers. The only correlation that could be drawn with income is the low proportion among those earning below B2,000.

Table 4.43 Respondents Agreeing with High Risk Beliefs and Practices by Income

Practices and beliefs	Income in baht				
	<2000	2-4000	4-6000	>6000	Total
Kheun khru	39.4	50.0	50.0	64.7	46.5
Condoms and bravado	34.4	46.8	54.8	52.9	43.1
Implants and injections	3.1	8.7	15.0	23.5	8.1
Alcohol and virility	15.6	30.4	47.6	35.3	26.9

Whereas earlier findings showed that low income was associated with low education and low knowledge of HIV/AIDS, and thereby some susceptibility to HIV infection, this data indicates associations with higher incomes and belief in, or ignorance of, high risk behaviours. The correlations are not strong but at the very least they suggest that respondents who agree with these propositions come from all income categories.

The implication is that high incomes make for greater spending power. Fishermen, as high income earners, are more likely than others to agree with these high risk practices and beliefs, and it has been shown that many fishermen are not good savers, squandering their money on sex, drinking and gambling. These findings appear to support the thesis that a group of hard core men may be responsible for much of the spread of HIV.

In order to corroborate these findings the variable 'ever using condoms with sex workers in the last year' was tested with each of the above questions on high risk practices. There was only one question that demonstrated any correlation, where a distinctly high proportion of those claiming to never use condoms agreed with the practice of *kheun khru*. Cross-tabulating the question with the variable of 'how many times with sex workers in the last year' also demonstrated a similar correlation with *kheun khru*, and also with male bravado and non-condom use. A high proportion of respondents with over 15 sex partners in the last year agreed with these beliefs.

Attitudes regarding acceptable norms of sexual behavior.

Respondents were asked to agree or disagree that certain sexual relationships were acceptable or not. Men generally agreed more than women that pre-marital and extra-marital behaviour is normal and thereby acceptable. These practices can be considered to be taboos, or in contradiction to general community standards, but with varying degrees of censure. The first set of three questions as set out in Table 4.44 refers to unmarried men and women, and the responses, predictably, demonstrate a strong double standard, allowing men a high degree of sexual freedom compared to women. This is affirmed in three further questions pertaining to married people.

Almost equal proportions of respondents agreed and disagreed agreed with single men having sexual relationships. And similar proportions agreed with single men having sexual relationships either with sex workers, or other partners, 44.9 and 47.1 respectively. However, 76.2% suggested that single women should *not* have sexual relationships.

There was strong disagreement (91.5%) with married women having sexual relationships with men, however, over 20% suggested that it was acceptable for men to have relationships with sex workers, or with other women.

Table 4.44 Acceptability of Sexual Relationships

Sexual relationship	Agree	Not agree	Don't know	Total
single men with sex workers	47.1	45.0	7.9	100.0
single men with other women (not CSWs)	44.9	46.1	8.9	100.0
single women with men	16.4	76.2	7.3	100.0
Married men with sex workers	21.0	74.0	5.0	100.0
Married men with other women	22.9	70.3	6.7	100.0
Married women with men – not spouse	3.8	91.5	4.7	100.0

When testing for other variables there are few correlations that could be made. Men are certainly more accepting than women, which contrasts to only a marginal difference between men and women respondents in Aranyaprathet. The most distinct difference between men and women respondents in Trat was on the question of married men visiting sex workers, 27.1% of men agreed compared to 7.5% of women. This is the only question where there is a distinct difference between responses of married and single respondents, with 15% of married people agreeing compared to 27% of single respondents. There is no correlation with education except that in three of the six questions those respondents with over nine years of schooling are less likely to agree with such behavior being acceptable. Which is comparable with Aranyaprathet (see explanation in Aranyaprathet report).

Discussion and summary

The masculine behaviours, discussed here, are potentially very high risk behaviours and the high degree of acceptability in Trat suggests that these behaviours can still frequently occur while in many other parts of Thailand such practices and beliefs are thought to have significantly declined.

Fishermen are the most likely to agree with all of these practices, and this finding is consistent with the fact that men are much more likely to agree than women, and also that moderate and higher incomes are associated with agreeing with these practices. The only surprising finding here is that fewer Trat respondents agreed with marble implants and injections than did respondents in Aranyaprathet. While it would have been expected that such practices were more common, and thereby more acceptable, among fishermen, at least according to research in Ranong (see accompanying report), the difference was only marginal. On other practices and beliefs respondents in Aranyaprathet are much less likely to agree that they are acceptable.

In relation to beliefs on *kheun khru,* as well as non-condom use associated with male bravado, respondents were far less likely to agree in Aranyaprathet than in Trat, 20% compared with 44.9% for *kheun khru*, and 14.9% compared to 42.4%, for being brave in not using condoms. Similarly, slightly fewer respondents in Aranyaprathet, 20.3% agreed that there was an association between drinking alcohol and sexual stamina and virility, compared to 25.4% in Trat. This suggests that it is much more likely that respondents in Trat find these practices acceptable, and in terms of seemingly not acknowledging the associated risk have misconceptions regarding these potentially very high risk practices or beliefs.

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Table 4.45 Respondents Agreeing with High Risk Beliefs and Practices

Practices and beliefs	Aranyaprathet		Trat	
	No.	%	No.	%
Kheun khru	63	(20.0)	153	(44.9)
Condoms and male bravado	47	(14.9)	145	(42.4)
Implants and injections	36	(11.4)	26	(7.7)
Alcohol increases virility	64	(20.3)	88	(25.4)

Findings on attitudes to sexual norms in both sites reveal substantial differences, suggesting less conservative attitudes in Trat, where there is a high acceptability of single men and sexual relationships, and a comparatively high acceptability of married men and sexual relationships. There is closer agreement on the non-acceptability of females and pre-marital or extra-marital sex. Thus, there is even a greater discrepancy in what men can do and women should not do! While the attitudes are referred to as 'less conservative' this is only in regard to male sexual behaviour.

There is consistently higher rates of don't know/not sure responses in Trat but not substantially higher. However, it is clear that the proportions of men are higher and account for some of the difference in the two sites which suggests that characteristics of the 'male culture' are strong here, and this is associated with men being away from home and families, such as fishermen.

Table 4.46 Acceptability of Sexual Relationships: Comparing Trat and Aranyaprathet

Sexual relationship	Percentage agree	
	Trat	Aranyaprathet
single men with sex workers	47.1	35.3
single men other women	44.9	35.1
single women with men	16.4	15.8
Married men with sex workers	21.0	4.1
Married men with other women	22.9	9.2
Married women with other men	3.8	0.9

These findings are consistent with the above findings on masculine behaviours and high risk practices. The men who hold these attitudes are often fishermen, or they may be saw mill hands who are men living way from their families as well. These men may belong to a hard core group of people who have practiced these very high risk behaviors. It can be very difficult to change such behaviour or correct misconceptions among this group. However, by providing accurate education that dispels such misunderstandings to the general community it is possible to gradually change risky practices. Attempts have been

made by World Vision in Ranong to target some of these practices directly. It is important to investigate such beliefs and practices but in broader terms it is the male culture that needs to be examined.

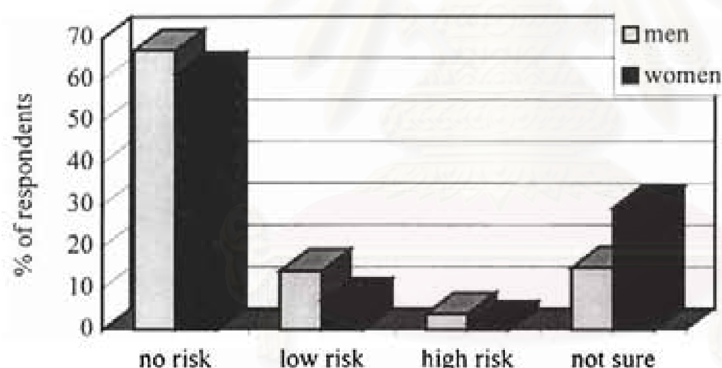
4.9 Sexual Behaviour and HIV Risk Situations

Initially in this section self-assessment of risk is discussed followed by condom awareness and self-reported sexual behaviour and condom use. Following the sequence in Chapter 3 discussion on sex work concludes the section but here includes quantitative as well as qualitative data on sex workers.

Self-assessment of risk and other self-reported behaviours

Most people did not see themselves at risk of infection, 65.2%, while 11.8% estimated low risk, and just 3.2% admitting to high risk, 19.6% are unsure. Of the 11 respondents who saw themselves at high risk, nine are men, and most are single. Those who saw themselves as low risk are mostly single men. Fishermen have the highest proportions of those who assessed themselves as low or high risk, closely followed by saw millers and agriculturalists. There is no correlation with education.

Figure 4.25 Self-assessment for Risk by Gender



For most respondents, 79.3%, the fear of death is the main reason why they would want to protect themselves. Others are concerned with embarrassment or shame, 17.5%, and in contrast to Aranyaprathet only 2.6% are fearful of transmitting HIV to their family.

Drug use: risks and attitudes

Most people admitted to occasional drinking of alcohol, 44.7%, while 8.5% admitted heavy drinking. The picture is almost reverse in relation to smoking cigarettes with 36.1% heavy smokers and 14.2 very light smokers. Ten people, 2.9%, admitted to having

used marijuana but claim to have quit. Similarly with amphetamines, seven people admitted to use but claimed to have quit.

Only six people admitted to sharing syringes, and the same number admitted to injecting heroin. Four people have received blood transfusions. Most people have negative reactions to drug users, 69.5%, while 20.5% saw them as not bad people, as did the remaining 9.1% who report that it is a personal issue and thus they should not be judged. Similarly, only 5.9% agreed that drugs can help to relieve stress, although 47.6% respond by saying they don't know/not sure.

Condoms: knowledge and attitudes

Most campaigns emphasize the use of condoms in commercial sex as a means to slowing the rapid spread of HIV. In Thailand, such campaigns have had an effect and the 100% condom policy is now being used in parts of Cambodia. Condom use has risen significantly, from 14% to over 90% in Thailand and is rising in Cambodia, however, reports from Cambodia suggest condom use is still inconsistent, and reports from other border areas in Thailand suggest inconsistent use (Tarr, 1997; CARE Cambodia 1999).

Initially it is important to ascertain how well the targeted population is aware of condoms. In the study sample 18% claimed to have never heard of condoms. The majority of these are women, almost half of all women respondents, and the bigger proportion is single women; however, 7.8% of men (n=18) claimed to have never heard of condoms as well.

Of those who have heard of condoms most had come across them by seeing them at a shop. Data collected from sex workers is excluded in this section and presented separately in the following section.

Table 4.47 Exposure to condoms by gender

Place	Men %	Women %	Total %
Store/shop	175 (81.0)	44 (91.7)	219 (83.0)
Friends house	147 (68.1)	39 (81.3)	186 (70.5)
Hospital	143 (66.2)	25 (53.2)	168 (63.9)
Other	143 (62.0)	35 (72.9)	178 (67.4)

For most men, 80.9%, the first time a condom was used was with a sex worker. It is clear from the data that condoms are associated with commercial sex and with STDs rather than for contraception. Among men 53% identified condoms as a precaution for STDs; however, a further 36.5% identified condoms as both a protection against STDs but also a contraceptive. The proportions are much lower for women, 41.1% for STDs, and only 14% identifying both; 5.6% suggested birth control only and the remaining 37.8% are not sure/did not know. Married people have slightly higher responses than single people.

There is little variation among different levels of education, although people with over nine years of education have higher proportions responding that condoms protect both against STDs and pregnancy.

Table 4.48 Reasons for Using Condoms by Gender

Condoms used for	STDs	Birth control	STDs & Birth control	Don't know/ not sure	Total
Male	122 (53.0)	3 (1.3)	84 (36.5)	21 (9.1)	230 (100)
Female	37 (41.1)	5 (5.6)	14 (15.6)	34 (37.8)	90 (100)
Total	159 (49.7)	8 (2.5)	98 (30.6)	55 (17.2)	320 (100)

Respondents claimed to have gained this information from a range of sources, however, through friends or relatives is the most common source, 37.3% of the total sample mentioned this source. Men have distinctly higher proportions in all categories.

Table 4.49 Source of Information for Hearing about Condoms

Source of information	Friends	Health officer	TV	Radio	News-paper	Poster	NGO	Other
% of sample	37.3	37.0	16.6	13.9	8.7	7.2	4.8	4.5

Many people have different perceptions regarding whether condoms detract from sexual pleasure, or influence love-making in other ways. It is important to know and understand these perceptions, which may be derived from experience but also may partly arise from hearsay, as they may influence condom use. If certain attitudes are strong then marketing approaches may target such attitudes, and general educational approaches can attempt to change such attitudes.

Most respondents, 59.9%, are not concerned with or expressed no adverse effects from condoms, however, 21.1% claim that condoms decrease their pleasure, 10.6% say that condoms make them take longer, and 4.9% claim that they have no feeling when using condoms. There is very little difference in attitudes between married and single people.

Most fishermen say that condoms do not affect their pleasure, 61%, however, 26.8% claim that they do decrease pleasure. Interestingly, few thought that condoms make them last longer, only 3.7%, whereas this is a complaint of other occupational groups, especially farmers, as much as 37.5%. This may be a side effect of the fishing industry where men are away from sea and build up a sexual appetite, and thus they never take a long time.

Pharmacists in Khlong Yai provide condoms for fishermen but sales are slow, especially as condoms have been distributed for some years now for free to various sites, such as one main hotel, all known brothels, and one store in the red light area, in addition to

distributing them through health volunteers. CARE is now distributing them more widely. However, qualitative and quantitative survey findings suggest that there is still some resistance to consistent use of condoms.

Sexual relations, and condom use

Of the total sample, or 287 who responded to this question, 83.9%, have had a sexual relationship. The proportions of women (n=55) and men (n=287) are almost identical. It is more common that women's sexual debut, their first time for having sex, is at 18 years of age or under, than it is for men, 60.3% of all women, compared to 34.7% of all men. This may be due to Cambodian women marrying at an early age. The percentages of men having first sex at 19, 20 and 21 years of age is much higher than women, and one other report confirms a relatively late sexual debut for males (UNICEF & CARE 1999).

Figure 4.22 Sexual Debut (first sex) by Age

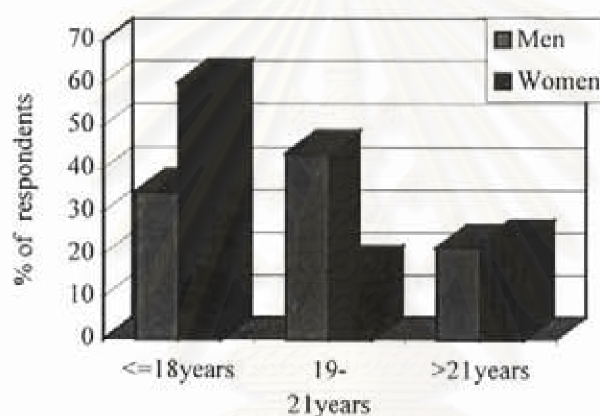
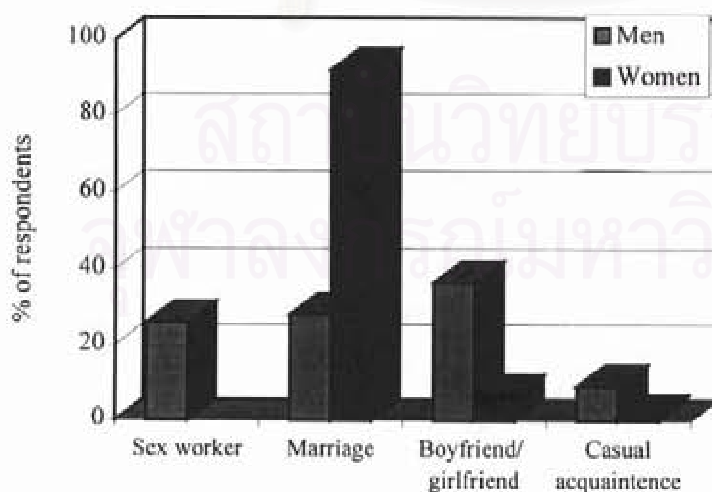


Figure 4.23 Sexual Debut with Whom by Gender



Cross tabulations with marital status show that single women stated more than married women that their first sex was below 18 years of age, 57.1% compared to 32.8%, which may indicate that age of first sex is decreasing.

Sexual debut for 26% of male respondents was with a sex worker; however, 28.1% say within marriage, and 36.5% with a girlfriend. For women, 92% say within marriage and 6.7% with a boyfriend.

The data discussed below confirms other findings of inconsistent condom use in commercial sex and very low condom use outside of commercial sex. Most respondents reported having had commercial sex relations, of all single men 61.7% admitted to having had sexual relations with a sex worker, and for all married men it is 51.5%. Most admitted to 1-4 times per year but 38.3% estimated 5-15, and 15.8% more than 15 times, the latter included three admitting to 36 times and one 48 times. There is little variation between single or married men.

Figure 4.24 Respondents Who Visit Sex Workers by Frequency of Visits

Those who had more than 15 commercial sex partners predictably are among higher income earners, in addition they are mostly well educated, with most having 6-9 years of education, and fortunately they are more likely to use condoms. Most of them are from the sawmill, eight respondents, 11.9% of all sawmill workers, and eight are fishermen, 7.2% of all fishermen.

The last time respondents had sex, 50.6% of men, mostly single, say it is with a sex worker. For women 90.6% it is within marriage (or regular partner), compared with men the proportion is 37.8%. The last sex for 14 married men, 17.5%, is with a sex worker, and for seven, 6.1%, it is other women beside the spouse. Three women admit to sex outside of their marriage. Fishermen are more likely to admit to having had sexual relations with sex workers, 70.5%, and 65.4% report that their last sex is with a sex worker.

Table 4.50 Last Sexual Episode with Whom by Gender and Marital Status

Status	*Gender*	*Boyfriend/ girlfriend*	*Marriage/ reg. Partner*	*Sex worker*	*Casual Encounter*	*Total*
Single	*Female*	2 (50.0)	2 (50.0)	-	-	4 (100)
	Male	9 (11.3)	-	65 (81.3)	6 (7.6)	80 (100)
Married	*Female*	2 (3.6)*	52 (94.5)*	-	1 (1.8)	55 (100)
	Male	3 (3.8)	62 (77.5)	14 (17.5)*	1 (1.3)	80(100)
Total		16	116	79	8	219(100)

*In addition (from left to right) females - 1 divorcee, 4 widows, and males - 1 divorcee, 1 widower

There were a few questions that test frequency of condom use. Of course the questions pertaining to visiting sex workers were only asked of men. Other questions on sexual relations were asked of both sexes.

The first question is, 'did you use a condom the last time you had sex with a sex worker'? Most respondents say that they did, of 84 single men who visited sex workers 73.3% claim to have used condoms the last time, and of 53 married men 58.5% say they did use condoms.

The next question was on condom use in the last year with sex workers. Most claim that they always used condoms, 59%, while 23.7% say sometimes, and 17.3% say never. Responses from single and married men are almost identical. Those with a higher education are more likely to respond that they always use condoms. Fishermen are far more likely to respond this way as well, 71.1%, which corresponds with higher income earners responding in the same manner and respondents from Had Lek, where the fishermen come from.

The final question referred to using condoms with a person outside of marriage or established relationship. The proportions are similar to the above question for men, and only 23 women responded with 18 out of 23 saying that they would never use condoms, 14 of these women are married. This is an indication of low use in non-commercial sexual contacts and is consistent with many other studies where condom use outside of commercial sex is very low.

A recent report confirms inconsistent use of condoms even though all sex workers provided condoms. There were some reports of an extra charge for condoms and reports of condoms not being used with boyfriends or regular customers, and not when men are very drunk (Press 1999).

Table 4.51 Condom Use with Sex Worker
Condom Use with Other than Spouse

	Using condoms in last year with CSW	Using condoms with person who is not spouse (or regular partner)	
How often	Men %	Men %	Women %
Never	24 (17.3)	29 (20.9)	18 (69.2)
Sometimes	33 (23.7)	27 19.4)	3 (11.6)
Always	82 (59.0)	83 (59.7)	5 (19.2)
Total	139 (100.0)	139 (100.0)	26 (100.0)

Commercial sex

Commercial sex is responsible for the rapid spread of HIV in Thailand and Cambodia, it is the 'first wave' of infection, but from the commercial sex nexus HIV is spread through sexual networking outside of commercial sex. Men infect sex workers and in turn other men are infected and then spread the infection to wives and other partners. This two-way process may be facilitated by sex workers having boyfriends, or regular clients, where condom use is generally low.

It is important to determine the locus of infection, which is the network associated with commercial sex, at least in the earlier stages of an epidemic. Sexual networking is often defined as sexual contacts outside of commercial sex; however, the bigger picture of sexual networking includes both commercial and non-commercial areas which can overlap and sometimes cannot be clearly defined as one or the other.

While the brothels and more or less direct sex work can operate only in the Khlong Son area of Khlong Yai, indirect sex work does occur in the township of Khlong Yai sub-district, mostly with Thai women. There are several karaoke bars and restaurants where women may be found, in addition, there is one beauty salon and a massage centre where indirect, off the premises, services may be available. Women go to local hotels with customers and may go to hotels alone looking for customers. On a recent visit to one restaurant/karaoke bar we were informed that women in this establishment did not go *off* with customers, but Cambodian women could be arranged. In this same small restaurant with about five hostesses fishermen are among their main customers, but local Thais and officials also frequent the restaurant. Things are usually quiet early and late evening, we were told, but by 2AM some evenings it will be full. On busy nights the singing and drinking continues till 6AM or 7AM!

As stated brothels are thinly disguised, usually as karaoke bars, in the Khlong Son/Khlong Makam fishing area, with 10 to 12 establishments that the health department can identify as direct sex work. The hospital officials say they can only go to places

known for direct sex work. The owners cooperate with the hospital and a regular supply of condoms is assured and the workers are tested for HIV. By day these bars are just old timber homes that come alive after dark. As early as 5PM fishermen may be seen drinking at the bars.

A new red light district has been established recently in this area. Some of the new establishments have moved from the Khlong Yai town area, which confirms the fact that law enforcement, which is upheld elsewhere, does not occur in this fishing enclave. Large brothel areas have been proscribed in Thailand in recent years and have virtually disappeared, being replaced by more discrete establishments, which provide mostly indirect services. It should be stated, however, that soon after the survey was undertaken in January some of the brothels were raided and women and owners were fined. CARE Thailand undertook their survey at around the same time. Apparently there have been no raids since this time.

In Koh Kong and on the islands there appear to be very few restrictions and direct sex work flourishes. As stated there are two major areas in Koh Kong, Sao Tong and Pak Khlong, where up to a thousand sex workers may be found, many servicing fishermen but also police, soldiers, traders and others. And now a third area, in close vicinity between the border and Pak Khlong, Ban Mai has been established. This is a new area and after inquiring why sex work establishments have sprung up in this new village area, which is not a port, informants report that Thai men cross the border and visit sex workers here.

This confirms other reports from key informants and sex workers themselves that Thais still actively seek out sex workers, which contradicts other informants claims that Thais rarely visit sex workers these days due to AIDS. One of the Cambodian sex workers reports that she regularly had Thai customers even though they were mostly Cambodian, but she also has had Mon clients from Myanmar. She confirmed other reports from Trat and Aranyaprathet that Thais are more likely to be aggressive and wanting to use different positions, *len tha;* however, many of these Thais are police or soldiers.

Sex workers

Thirteen sex workers were included in the questionnaire survey. These workers are from Khlong Son, the main red light area in Khlong Yai. There are Vietnamese and Cambodian workers in this area mainly servicing a Cambodian clientele but may include different nationalities of fishermen and local or visiting Thais. Some of the women here are attached to thinly disguised brothels while others, such as the women interviewed here, act as street walkers, taking their customers back to their rented rooms. Eleven of the women lived alone and the other two share with women.

The sample of sex workers is small thus it cannot be representative, however, most of these women are relatively new to sex work and thus may be representative of the

general awareness of HIV/AIDS of many young women entering the sex trade. Their knowledge and understanding is generally below that of the total sample. Four claimed to have never heard of STDs, and given their age and the short period of time in sex work this is perhaps not surprising. On the two important questions; namely, 'can AIDS be cured?' and, 'does a HIV+ person necessarily have to have symptoms?', proportions of correct responses are distinctly lower than the total sample.

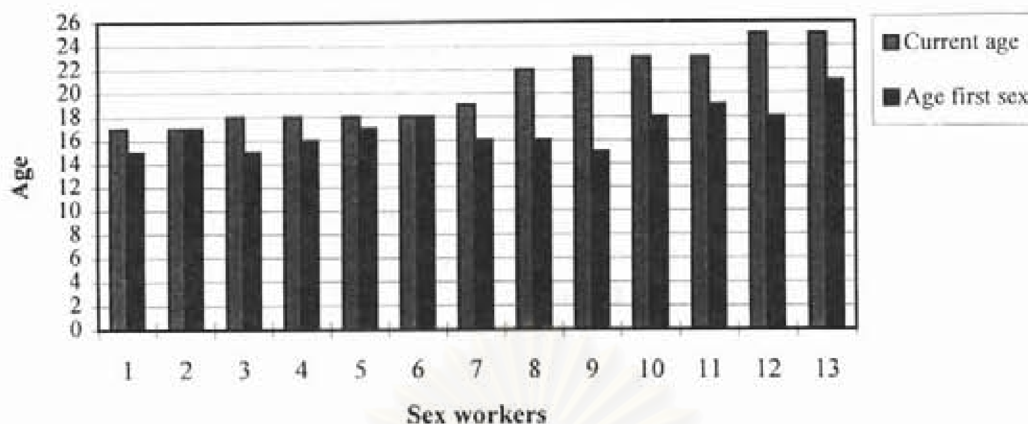
On transmission they are more likely to respond correctly only with regard to one question, namely, condom use will prevent HIV transmission. On all other questions they have similar or lower responses than the total sample. On whether having sex with a person who looks healthy is protective, five say yes and seven say don't know/not sure. This is a critical question as it is well documented that sex workers in Thailand have had unprotected sex because they thought that they could tell if someone is healthy by appearance. Nine are unsure whether infection could occur in unprotective sex where the withdrawal method is used, and five thought that having their blood tested by health staff every three months is protective, six are not sure.

Only three have been to the Thai hospital, but eight are aware of medical services being available in Thailand. Out of the 13 women, 10 are single, 2 divorced, and one married. Individual incomes varied but on average is relatively high with four earning between B4,000 to B20,000 and one earning over B20,000. Nine have five years or less of schooling including four with no formal education; two have 6-9 years and two over nine years.

Seven are under 20 years of age (see Table 4.26). The age of first sex is lower than that of other women with 85% having sex for the first time at 18 years or less (Table 4.26). For most, the first time they had sex was with a boyfriend, and one says a spouse, three others say with people they knew in the community, and the other three say customers, which means they may have been sold as virgins. For nine women the first time they used condoms was with customers, one was with a casual acquaintance that they knew in the community, and the other three are not sure.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

Figure 4.26 Sex Workers: Age of First Sex and Current Age



Twelve claimed to not be able to speak Thai at all, with one saying a little. Their ability may be underestimated by themselves or the Khmer interviewer, although it does appear that comprehension skills are better than their ability to speak Thai, and this is attested to by three saying that they have some comprehension skills and one saying good comprehension skills. It is likely that some of them would have Thai language skills although for most the period of time spent in Thailand is short. Five of the workers report that they have been working in Thailand for only one month, another five for less than seven months, and two report over two years.

It is possible that some of them under-estimated the period of time. It is quite common that sex workers will say that they have been working only a few months when asked, however, they may be referring to their current work situation only, rather than prostitution generally. Thus, in this situation they may be referring to the current period of work as they may have worked here previously, perhaps alternating between working between Khlong Son, Koh Kong and on Koh Kut (see below). However, testing several variables it seems that their stories are accurate. For eight of the women it is their first move, three moved to Khlong Yai via Phnom Penh, and three came via Koh Kong. This is further verified by another variable which shows that for ten of the women this is their first time in Khlong Yai, for three it is their second time, and one woman has been here 10 times, indicating the regular movement of sex workers to different sites.

The usual scenario, which has been common in Thailand as well, is that agents or owners move the women around from one area to the other. In Aranyaprathet this is common, and in Trat one informant suggested that women are regularly moved between Khlong Yai, Koh Kong, and Koh Kud. However, it does appear though that in Trat the movement may be more on the initiative of the women than the owners or agents.

Qualitative findings suggest that women move from Khlong Son when the numbers of fishermen are low. In the most recent visit to the area it was estimated that there was perhaps only a 100 or so women present due to many fishermen being away. Thus, over

time hundreds of women have moved, most of them apparently moved to the island of Koh Kut. Prices in Khlong Son are relatively cheap, often B100 for a short time, prices on Koh Kut are generally more expensive, so even if there are not enough fishermen they may still earn a reasonable income. Koh Kut is documented in the Mahidon report as a place where sex work was common in various sites with Thai, Cambodian and Vietnamese sex workers (Pramualratana 1995). It is reported that as many as 300 boats can dock at the main port of Ao Yai, but there are many other smaller ports. It is likely that as elsewhere the sex workers are now only Cambodian and Vietnamese.

Entering the sex trade: some experiences

Six of the women report that they first came to Thailand or to the border region under their own initiative, two say with friends, another came with relatives. This is consistent with other reports of women coming by themselves or with their mother, and as discussed in Aranyaprathet. These women still have to pay off debts for loans or pre-payments, which they may then give to their family, just like other women, such as the three who appear to be recruited by agents, one a Thai agent, the other two report that Cambodian agents introduced them to the work.

No informants interviewed are aware of any establishments providing virgin girls. As the brothels are small and women have some independence this may not be as prevalent as it is in Aranyaprathet. It may be more common in Koh Kong. However, three women I the above survey state that their first sex was with a customer, which suggests that they were sold as virgins. In the qualitative research one woman (*pseudonym*: Bupa) related her story of how she was sold as a virgin in Phom Penh. A man bought her for one week and apparently treated her well, staying with her each night while working by day. She is originally from Kampong Cham and was apparently tricked into the business in Phnom Penh, thinking she was going to work in a restaurant. She then went to Sao Tong, Koh Kong where she worked in a bar, sitting with customers and sometimes going *off* with them. Friends persuaded her to move to Khlong Yai but now she wants to return to Koh Kong and work in the bar rather than the current situation where she hires a room and goes out to entice customers to come back to her room. There are many bars in Sao Tong, Koh Khong, it is not clear how many may provide rooms on the premises or whether they hire or use rooms outside.

Bupa is quite new having only been in the area for less than a month, therefore, she can command a high price, B300, rather than B100 which many charge. She claims to have travelled to Khlong Yai with a girlfriend by catching motor bikes, which means they would get a border pass at immigration which should not allow them to pass from Had Lek into Khlong Yai sub-district. It is not clear how the women cross through the check-point. The whole trip cost her B500 which may include expenses at the immigration check point, and at the check point in Had Lek before reaching Khlong Yai. Of the above 13 sex workers nine passed the official immigration check-point while three say they did not, which suggests that they came by boat.

Another woman, Prim, followed the same route but under different circumstances. She worked in a bar in Phnom Penh after being jilted by her boyfriend, and then voluntarily moved to Sao Tong where she also worked in a bar, thus, Khlong Yai was the first time she worked in a brothel rather than in indirect sex work. The first woman from Phnom Penh, Bupa, says at first she did not use condoms but came to realise how important it is, and now claims she refuses customers who do not want to use condoms. This would be difficult to maintain, it appears, as she claims many customers do not like to use condoms. The second woman, Prim, also reports that many men do not wish to use condoms and admitted that she will forego using them at a price. Some men it seems are willing to pay up to B500 extra not to use condoms.

Two of the 13 women from the survey data paid agents to find work in Koh Kong, one 23 year old gained work as a maid, but now she regularly works as a sex worker having worked in Khlong Yai on 10 different occasions. Another women from Phnom Penh, 18 years old, first moved to Koh Kong claims to have travelled to Phnom Penh out of curiosity and a friend persuaded to come to Khlong Yai but she did not realise the type of work involved but she had no money to return. She has been in Khlong Yai for four months and hopes to go home very soon when she has enough money.

Attitudes to Thais

Analysing their attitudes to Thai people provides some insights, for attitudes to Thai people generally are very similar to the total sample, as is their attitudes to health officials, however, to employers and police/soldiers their attitudes are more negative. In regard to employers only 46.2% of respondents describe their attitude as good, compared to 82.2% of the total sample, and 15.4% not good compared to 2% of the total sample. In regard to soldiers/police/border officials 46.2% respond with 'not good' compared to the total sample of 23.2% of the total sample, and only 7.7% say 'good, compared to 37.7%. This is perhaps understandable given that such officials can extort money from them as illegal migrants, and as illegal sex workers police can collect protection money from them. One of the women above told how she paid the police B1,500 per month, for 'protection'. Police and other officials are also among the most common clients and are generally not liked as clients.

Discussion and summary

It is clear from the above data that sexual networking, particularly through commercial sex is highly prevalent. Migrant men residing in, or transiting through, Khlong Yai are often single, or married men away from home. There are hundreds of sex workers in Khlong Yai, mostly Cambodian but also Vietnamese. A high proportion of their customers are Cambodian fishermen and the number of sex workers at any given time is largely dependent upon the movement of fishermen.

Migrant fishermen and other male workers may also visit sex workers in other areas, particularly in Koh Kong where condom use is reportedly lower than in Khlong Yai, and STDs are more prevalent. Thai men also visit sex workers across the border as well as in Khlong Yai. The data supports claims that condom use in Cambodia, as well as in border areas of Thailand, is inconsistent and generally lower than that found in most parts of Thailand.

Both single and married men, over 60% of all men, report multiple commercial sex contacts in the past year, with as many as 30 or more contacts for some men. While a minority of men report no condom use in the most recent time they had sex, or, report never using, or occasionally using condoms in the past year with sex workers, the numbers are substantial, indicating a relatively low use rate.

Condom availability may not be the major problem so much as resistance to consistent condom use. Condoms have been distributed free for some years and distribution is being enhanced by the work of CARE. Even in Koh Kong PSI marketed condoms are available at reduced prices and joint programs between hospitals at Khlong Yai and Koh Kong should be assuring reasonable distribution but this is uncertain.

The resistance to condoms is reported directly by respondents and also by sex workers who attest to the fact that many men do not wish to use condoms. While 60% reported no adverse reaction others say that condoms decreased pleasure, or totally took away any pleasure, and others claim that condoms made them take too long. Marketing approaches should accompany distribution processes so that messages and other educational approaches are designed to target such attitudes.

Almost half of all women report never having heard of condoms, and most report never using condoms. Most women have never used condoms (this excludes sex workers). Only about a third of the total sample report knowing that condoms are protective against STDs as well as being a contraceptive. Condoms are mostly associated with STDs and commercial sex, indicating very little use outside of commercial sex. Sex workers have better knowledge on condom use but generally their knowledge on HIV/AIDS is poor. This is understandable given that seven of them are under 20 years of age, and not in the trade very long.

Resistance to condom use may be high among certain men who regularly practice high risk behaviours and have many partners. While there is limited evidence to support this, there is a correlation with men who had over 15 sex workers in the last year and not using condoms. In addition, there is a correlation between low condom use and a high proportion of respondents who agreed with the practice and belief of *Kheun khru* (sexual initiation by a sex worker), as well as those believing in the association of male bravado – expressing courage through non-condom use.

Some of these men also have high incomes, such as fishermen who rated highly in all questions pertaining to commercial sex visits, although many fishermen made claims to relatively high condom use. Many fishermen also have relatively high knowledge; however, does not necessarily translate into safer sexual practices, such as reductions in numbers of sexual partners or higher condom use. Beliefs and attitudes may be higher predictors of unsafe practices. While vulnerability to HIV infection may be enhanced through low knowledge and low income, almost the converse can be true. High income earners may be high spenders, they certainly have a greater capacity for spending on entertainment which can lead to more risk situations through greater and access to sex workers or casual sexual partners. Police, border officials, and soldiers are numbered among the clients of sex workers. They have relatively high incomes, and education, and hopefully HIV/AIDS awareness. Yet there is evidence that they do not always practice safe sex, and some of them certainly have multiple sexual partners. The police have the highest infection rates in Cambodia after sex workers. There are reliable reports that Thai police, and their wives, have died from AIDS but that it is not being reported as AIDS by the hospitals.

With this understanding on male behaviours in Trat, and from the previous section where it is clear that through attitudes to sexual norms, as well as to potentially very high risk behaviours, men in Trat, and mostly fishermen, have cultural norms that are associated with 'male culture'. Such cultural norms when considered in the context of risk situations, and masculine behaviours that are given credibility and not viewed negatively, can give rise to the rapid spread of HIV, and HIV is spreading rapidly in the border area.

Multivariate Analysis

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

HIV/AIDS Knowledge

Knowledge, as the dependant variable, includes general knowledge of HIV/AIDS as well as knowledge on transmission and prevention. These three areas of knowledge were combined to form overall knowledge for this analysis. The predictors are selected from 16 demographic and migration variables which are all tested against knowledge as the dependent variable. They are selected according to the theoretical conceptual model, presented in Chapter 2, and the study findings.

Demographic variables were: age, gender, education, marital status, occupation.
Migration variables were: hometown, previous occupation, encouragement for migrating, prior information before migrating, relative in hometown, contact with hometown, frequency of visiting hometown, income, savings, sending remittances, length of stay,

place of living, living with whom, community participation, recreation activities, Thai language skills. Another variable was self-assessment for risk of contracting HIV.

Table 4.27 Multiple Regression of Demographic and Migration Factors plus Attitudes on HIV/AIDS by Knowledge

Predictors	β	t	Sig
1. Gender - men	.277	2.253	.03
2. Place of living - in Khmer community	-.246	-2.002	.05
3. Place of living - in employer house	-.238	-2.736	.01
4. Marital status – divorced	.214	2.138	.04
5. Marital status – widow	-.212	-2.304	.02
6. Hometown - Takeo	-.193	-2.277	.03
7. Hometown - Phnom Penh	.186	2.140	.04

R^2=.582 F= 2.166 Sig.=.00

As shown in Table 4.27 the significant predictors for knowledge are as follows: Demographics: gender and marital status. Migration: hometown, place of living and hometown. Of a total of seven significant variables, three are positive and four are negative correlations with the dependent variable.

Men have a positive correlation with knowledge showing that they are more likely to have higher knowledge than women. Those living in Khmer villages as well as those staying in employer provided accommodation have a negative correlation meaning that they are more likely than others to have low knowledge. Divorced respondents are more likely to have higher knowledge while widow(ers) are more likely to have less knowledge. Those with their hometown in Takeo were likely to have less knowledge while those from Phnom Penh were likely to have more knowledge.

Risk behaviour

Risk behaviour, defined here as multiple partner sex (with casual partners or sex workers) is the dependent variable. The predictors are selected from the demographic and migration variables, described above, plus attitudes on two areas, namely: attitudes toward PWHAs and attitudes toward social norms. In addition, other variables are the overall knowledge score and self-assessment of risk.

Table 4.28 Multiple Regression of Demographic and Migration Factors plus Attitudes on HIV/AIDS by HIV risk (multiple partner sex)

Predictors	B	S.E.	R	Sig
1. Visiting hometown – regular	.9231	.3920	.1234	.02
2. Place of living – stay in boat	1.3419	.6231	.1064	.03
3. Income – higher income	4.18E-05	2.167E-09	.0861	.05
4. Self assessment – higher risk	1.2938	.2715	.2982	.00

Predicted percent correct = 77.62 Chi squared = 42.023 Sig = .00

In Table 4.28 there are four significant variables, and one negative correlation. Those regularly visiting their hometown, compared to those who do not, are more likely to have multiple partner sex. Those staying on boats, namely fishermen, are also more likely, and given that many have relatively high incomes, such incomes have a positive correlation with multiple-partner sex. The few people who assessed themselves at high risk also are likely to have multiple-partner sex.

Risk behaviour

Risk behaviour, defined here as sexual relations with sex workers, is the dependent variable.

Table 4.29 Multiple Regression of Demographic and Migration Factors plus Attitudes on HIV/AIDS by HIV risk (sexual contacts with sex workers)

Predictors	B	S.E.	R	sig
1. Thai comprehension – good	1.0368	.3232	.2608	.00
2. Place of living				
– Stay in boat	1.5599	.6347	.1821	.01
3. Remittances - sends money home	- 7.-E-05	3.341E-	-.1406	.04
4. Self assessment – higher risk	1.7542	.05	.1711	.02

Predicted percent correct = 71.11 Chi squared = 29.985 Sig = .00

In Table 4.29 there are four significant variables. Three are positive correlations, that is, higher probability to visit sex workers. Those who fit this category are those with good Thai comprehension, those who live on their boats (fishermen) and those who assess themselves at high risk. The negative correlation is with those who remit money home, suggesting that those who remit money home have a low probability to visit sex workers.

4.10 Attitudes to People with HIV/AIDS

The above findings on transmission of HIV showed that between 40% to 50% of respondents agreed with or were not sure of HIV being transmitted through touching, through sharing the same toilet, or glasses or clothes. Thus, for many people there is a fear of HIV transmission through casual contact, and this appears to determine some of the negative responses to living with people with HIV/AIDS, as reported below. Even though the above responses on transmission suggested considerably more awareness than that of respondents in Aranyaprathet, many of the responses below confirm a high degree of fear, which has characterised responses to most HIV/AIDS epidemics throughout the world, at least in the earlier years of the spread of HIV.

The majority of people, 51.3%, agreed that HIV is not easily communicated to others and thus people should not be stigmatised or avoided. This was identical with Aranyaprathet. However, 39.3% disagreed with the statement and 9.2% were not sure. Most people felt sympathy for PWHAs, 69.4%, but 24% did not. However, when interviewees were asked whether they could work with, or be a close friend to, a PWHA, 40.2% said that they could not; 48.3% said they could.

Most respondents said that they would visit a friend who had HIV/AIDS, 66.8%, and 24% said they would not. With the next question the proportion drops considerably, with 53.8% agreeing that a PWHA should be isolated with special care, and almost 20% not sure.

Only 3.5% of respondents knew of someone close to them who was a PWHA. If a member of the family had AIDS most people, 79.9%, would take them to the doctor, others would take them to the temple for special care, 5.6%, and others would seek special medicine, 4.6%.

Table 4.52 Attitudes Towards People with HIV/AIDS

Attitudes toward PWHA	Agree %	Not agree	Don't know	Total %
HIV not easily transmitted, should not be afraid	51.4	39.3	9.2	.100.0
Should have compassion and pity for HIV/AIDS person	69.4	24.0	6.6	100.0
Working with or being close friend with PWHA	48.3	40.2	11.6	100.0
Visiting close friend who is PWHA	66.8	24.0	9.2	100.0
PWHA should be isolated with special care	53.8	26.6	19.7	100.0

Each of the six questions was given a score of +1 for correct responses, -1 for incorrect responses, and 0 for don't know/not sure responses, and then divided by six to determine the means which was then compared using ANOVA.

Of the total sample, 28% of respondents were in the negative, with 65% in the positive, that is, having responded correctly for most of the questions. Correct responses suggest that the respondent was aware that casual contact with PWHAs was not risky and thus were more accepting. The remainder, 7%, were neutral, mostly having not sure/don't know responses.

Males had significantly higher rates of positive or correct responses than females. Single respondents had significantly more positive responses than married people. Widows/divorcees (n=15) actually scored the highest. There was a significant difference in those with no formal education and those with 1 – 5 years having low scores compared to those with over 6 or more years of schooling. There was no correlation with age, with those under 21 years old having the highest scores. Fishermen and sex workers, followed by sea transport labourers, had the highest rates of positive or correct responses with no significance. There was no significance with income. There was no significant correlation with Thai speaking ability, however, those with moderate or good Thai language skills had distinctly higher rates of correct responses than those with little of no ability to speak Thai.

In summary, Trat respondents were less likely to have misconceptions regarding transmission of HIV through casual contact than respondents in Aranyaprathet. Having more understanding they were a little more likely to have pity for PWHAs, and more likely to work with, or be close to their friend who has HIV/AIDS. Thus, they are much more likely to go and visit a friend, and substantially fewer respondents thought that such people should be isolated.

Table 4.53 Attitudes Towards People Living With HIV/AIDS Comparison of Respondents Who Agree in Trat and Aranyaprathet

Attitudes toward PWHA	Aranyaprathet	Trat
	% Agree	% Agree
HIV not easily transmitted, should not be afraid	51.3	51.4
Should have compassion and pity for HIV/AIDS person	62.8	69.4
Working with or be close friend with PWHA	35.9	48.3
Visiting close friend who is PWHA	48.6	66.8
PWHA should be isolated with special care	72.4	53.8

With most survey questions men have demonstrated more knowledge than women, and more knowledge and awareness appears to suggest a greater capacity to accept PWHAs, partly through having less fear. As HIV related illness and death becomes more common there may be more acceptance, a slow normalization process, however, the greater awareness people have before this occurs, the quicker they may respond in a positive way with less fear and stigma.

4.11 Health seeking behavior and HIV/AIDS prevention

Health Seeking Behaviour

Health seeking behaviour is problematic in many ways for migrants. Their illegal status plus language and socio-cultural problems, plus limited finances, can inhibit them from seeking treatment or limit the quality of treatment they receive. As well as not getting proper treatment for minor or more serious ailments they are not exposed to health information that may help them in diagnosing disease and in the prevention of disease. STDs are an example of a communicable disease that can be easily treated if diagnosed early and treated by qualified medics. Most communicable diseases can be prevented through straightforward safeguards, and this is true of STDs, including HIV.

In contrast to Aranyaprathet Khmer migrants regularly seek treatment from the hospital in Trat; however, it is only a small community hospital and only one person has reasonable Khmer language skills. This finding can be explained by the different situation of migrants in Trat where established Khmer communities exist, and generally migrant workers can stay in Khlong Yai without too much difficulty, even though some, like those in the saw mill, have to be careful of their movements. Another reason may be the better relationships between Thai and Khmer, largely due to the 'Thai Koh Kongs' and the existence of Khmer and Thai-Khmer communities.

The health stations in Trat, as in Aranyaprathet, also treat migrants for minor illnesses. Generally people must pay for treatment but some may get free treatment for minor illnesses, especially at the hospital, which over extends its resources as there is no separate budget to deal with migrants.

Only 12.7% of Aranyaprathet respondents had ever been to a Thai hospital, however, 52.6% of respondents in Trat reported having been to a Thai hospital. Another 41.3% said the reason they had not been was that they had never been sick. Of all women, 56% had been to the hospital, and of all men, 43.2% had been. Of all married respondents 60.8% had been to the hospital for treatment compared to only 33.3% of single respondents.

Mai Rud had the highest rates for the three districts, 59.1%, followed by Khlong Yai, 51.9%, and Had Lek, 42.8%. As for occupations, fishermen were least likely to seek treatment at the hospital, as were sex workers; the female dominated industries were

more likely to have employees going to the hospital. There was no correlation with income except for those respondents with an income over B6,000, 58.8%, compared to other income cohorts, in descending order, 45.2%, 47.2%, 46.9%.

There was some correlation with speaking Thai as shown in Table 4.57

Table 4.57 Ever been to Thai hospital and Spoken Thai ability by percentage

Spoken Thai ability	None	Low	Moderate	High
Ever been to hospital	23.9	50.4	62.9	72.5

Older respondents were more likely to have sought treatment at a Thai hospital than younger respondents, as represented in Table 4.58

Table 4.58 Ever been to Thai hospital with Age, by percentage

Age of respondent	>21	21-30	31-40	>40
Ever been to hospital	26	51	54.5	66.7

On the question of where respondents would seek treatment if ill the responses were consistent with current behaviour patterns regarding visiting hospitals, with 70.5% saying they would go to the Thai hospital, and 16.1% saying a Cambodian hospital. Other responses were, in order of most common response, Thai private clinic, Thai health clinic, pharmacy, traditional healer. The numbers with these latter responses was very small and may not reflect the actual situation. Qualitative research suggests that traditional healing is very popular and thus people may use it before visiting hospitals or in conjunction with seeking treatment elsewhere. Also it was found that in all three sub-districts Cambodians regularly seek treatment at the health stations. It may be that respondents have confused these with hospitals, or hospital services. The facilities and size of some health stations may be similar to the hospital in Koh Charng. In Had Lek most people seeking treatment at the health station are migrants crossing the border. In Khlong Yai 10-15% are Cambodian migrants, which is approximately 50 people per month.

Of 58 women who had given birth during the period of their stay in Thailand (the number in Aranyaprathet was 60, and only one in the hospital), 43 gave birth in a Thai hospital. Another six said they delivered in a Cambodian hospital, four said that they delivered the baby themselves, a few used Khmer medical attendants, and one a Cambodian private clinic.

Of 88 respondents who had children under one year old 62 (70.5%) had received vaccinations. Many did not know what vaccine it was and it was unclear whether they received multiple vaccinations.

Regarding the question on whether they, or a member of their family, had ever been ill with a disease that would prohibit them crossing the border, if detected, there were fewer responses than in Aranyaprathet, with ten people saying tuberculosis, and three malaria.

Most problems associated with health services in Thailand were to do with language 5.2% (n=18), and costs, 5.8% (n=20).

Health services and prevention of STDs/HIV/AIDS:

The existing public health services, especially the hospital, are in a good position to provide education and other services that deal with HIV and other STDs. The hospital at Khlong Yai has in fact been doing outreach work and providing materials in Khmer language and working with the staff from Koh Kong hospital. They have conducted training sessions for Thai staff as well as Khmer doctors. They have been able to do this with funding from Norwegian Church Aid, who supported these activities over five years, from 1993-1998. Now they have very little budget to undertake any of these activities. They have a special budget from the government to maintain condom supplies for some sex work establishments. They may be provided with some support from CARE who are now working the area.

Some of the problems facing the existing health services are outlined in the survey above. One of the major ones is language. The Thai government is obliged to provide some treatment for migrants in order to keep communicable diseases from spreading, and thus while there is no budget for migrants they can seek treatment for any ailments but generally at a cost, although treatment can be subsidised. As there is no budget there is no effort to provide translation services, or to provide any written materials in Khmer language.

Fishermen were the least likely to seek treatment from the hospital, some may go to health stations or go to Koh Kong, or self-treat. It has been reported that fishermen often seek treatment from pharmacies or use traditional medicine in Koh Kong (UNICEF). It has been reported that fishermen get STDs and go to sea without any opportunity for a diagnosis, and use whatever antibiotics are available on the boat. Sex workers were also more unlikely than others to seek treatment from the hospital. Thus, there is the possibility of STDs increasing despite the reportings of health officials.

Fishermen and sex workers are very mobile, from Thailand to Cambodia and to the islands and further afield. In its first programs CARE is focussing on reaching fishermen and through participatory approaches helping them to appreciate the risk that confronts them, and they are doing some preliminary work with sex workers.

Hospital officials in Khlong Yai and Koh Kong along with health station staff could be among the frontline workers providing education and support services. The hospital has much experience and this should not be lost due to a lack of Department of Health capacity to support the staff in continuing their work and in initiating new programs. The

community health centres could also be mobilised with volunteers working in conjunction with the hospital or the Public Health Department.

There should be increased, and follow-up, training in counselling for the increasing numbers of PWHA. Part of the program funded by NCA was for doctors from Koh Kong to come over one day per week to counsel Khmer people who were HIV positive. This program is under threat with no special funding available just at a time when it should be increasing.

Many of the health personnel know the living situation of migrants and understand their problems. Some come from the area and come in contact with migrants on a daily basis. Half of the patients at the hospital are Cambodian migrants. While there may be some animosity toward migrants relations appear to be good. This is supported in the survey by most respondents who reported that they had positive attitudes to both Thai employers and to Thai health officials. Thus the resources are there and only need to be mobilised through special health department funding or from other agencies.

Cross border collaboration between hospitals and NGOs on the Myanmar border has resulted in posters and other literature on a range of health issues being produced in appropriate languages. Initiatives in any prevention measures are in the Thai governments interest as there are, potentially, very high savings to be made. This is particularly the case with HIV/AIDS where the cost of care is expensive and also means the loss of labour, as most of the people dying from AIDS are in the prime of their working life.

According to informants in the hospital the district AIDS committee only meets on an ad-hoc basis as part of other larger district meetings. No serious meetings appear to have happened for some time. It is unfortunate that in a border area with very high HIV prevalence there is no concerted effort on behalf of the AIDS committee.

4.12 Conclusion and Recommendations

Summary of findings, Discussion, and Recommendations

Trat is six hours southwest of Bangkok, the district studied here is Khlong Yai which borders the province of Koh Kong in Cambodia. Many people crossed the border during the rule of the Pol Pot regime resulting in refugee camps in the area. Over the last few years during the repatriation of refugees there has been a steady rise in the number of migrant workers moving into Khlong Yai. Apart from the fishing industry, the saw mill industry has been one of the mainstays of the local economy. However, partly due to the economic crisis in Thailand saw mills have all but closed. The economic crisis appears to have had minimal effect on the fishing industry and thus migrants continue to cross the border for work in Khlong Yai. Recent developments in the registration of migrant workers and the accompanying enforcement of illegal migrants seems to be limiting the cross-border movement of some population groups.

For this study migrant workers were selected from eight occupational groups. The total sample was 346 respondents, 237 men 109 women. The core instrument in the research was a structured questionnaire, administered by locally trained bilingual researchers with the support of ARCM staff. Qualitative research through interviews with key informants and in-depth interviews with target group members was used for background material and to supplement quantitative data.

The fishing industry includes a fishing processing industry, and beyond this there is the labour employed on boats transporting fish products as well general cargo. Eight occupational groups are represented in the sample and the numbers of respondents are given below. At the time of the survey this was calculated as a proportional representation of those employed in the industries: fishing (n=111), saw mills (67), sea transportation (57), fishery related (47), agriculture (21), service industries (18) (restaurants/maids), sex workers (13), and traders (10).

Summary of Findings

Migration behaviour and conditions in the border region

1. In Had Lek sub-district there is a fishing port where hundreds of boats can dock, but also produce from fishing ports across the border is received here and transported as raw or processed products, as well as general cargo, to Bangkok.

2. Many people can avoid the only cross-border checkpoint by crossing to Cambodia by boat, however, among these crossings many are legal crossings partly due to the large local cross-border traffic as an outcome of the history of the area when many Thais lived in Koh Kong with Khmer communities. This is the only immigration check-point, situated at Had Lek it is increasingly busy due to the new casino.

3. Established villages of Cambodian migrants, and mixed Khmer and Thai communities exist in the fishing port area and are primarily dependent on the fishing industry.

4. Over three-quarters of single people are living in single accommodation, these are mainly men, and the proportions of married and single respondents are relatively equal.

5. Occupations, such as saw mills and fishing, employ single men without families and provide accommodation. Most are never married men, both married and single men are living away from their home. The other major employer of men is labourers who load and unload the boats.

6. Recent closures of most sawmills makes for even greater dependency on fishing.

7. Many migrant women are employed, and they are predominant in fishery processing as well as service industries, including sex work, and are also working as traders.

8. Women receive less pay, and on average have a lower education than men; they comprise 31.5% of the sample.

9. Respondents are from many areas but most come from Kampot, Kampong Cham, Koh Kong, and Phnom Penh. Over a third worked as farmers before migrating

10. Amost half the sample remits money home and the majority send remittances to their parents, often substantial sums of money. Thus, many single and married respondents appear to be supporting families back home.

11. Illegal status is a problem for many, it has been particularly so for those in saw mills who have had to be very careful moving outside of the work and living compounds, and enforcement of undocumented migrants is becoming more common.

12. Almost 20% have only been in the area for six months or less and a similar proportion over four years, with the remainder in-between.

13. Those who had been in the area longer were more likely to have proficiency in spoken Thai and in comprehension: Some correlations on HIV/AIDS knowledge could be drawn with Thai language, mainly with respondents who had no Thai speaking skills having low proportions of correct answers.

14. Half the sample has no contact with their hometown and 64% say that they have never visited their home. Over 20% visit home occasionally and the remainder return home more regularly: Those who return home regularly are more likely to have greater awareness and understanding of HIV/AIDS than the other two groups.

HIV/AIDS: awareness - attitudes - misconceptions

15. Awareness and understanding of HIV/AIDS is inadequate with many misconceptions on prevention as well as on some practices and beliefs that are potentially high risk behaviours.

16. Fear of PWHA even though most people identified casual contact as not being a means of transmitting HIV. Again, the data suggests that men have greater understanding and better attitudes than women, which supports the idea that more knowledge and awareness appears to suggest a greater capacity to accept PWHAs.

17. Low income and low education is associated with inadequate understanding of HIV/AIDS transmission as well as misconceptions on prevention and transmission.

18. Most women are in the category of low education and low income, and therefore they have less understanding of HIV/AIDS.

19. Sex workers have misconceptions on transmission and prevention and their overall knowledge of HIV/AIDS is limited, in contrats fishermen have relatively good knowledge.

Risk situations

20. High prevalence of HIV/AIDS on the border, particularly across the border in Koh Kong where STDs appear to be a major concern as well.

21. High risk situations with large commercial sex industries exist on both sides of the border, and in addition there are similar but smaller ports on islands in the area which are high risk areas.

22. Large populations of fishermen who spend their earnings on drinking and sex work when in port. Such risk behaviours are encouraged through life style and habits of crew and captains. Many are married, or never married men, living away from home.

23. Risk behaviours occur among high income groups as well as those who have a relatively good knowledge and awareness of HIV/AIDS, again the main group in this category is fishermen earning relatively high wages.

24. Higher income earners and those with prestige or authority, who should also have knowledge of HIV/AIDS, have easy access to sex workers and most of these are Thai, such as tourists, business men, uniformed men and other officials.

25. Condom use in commercial sex work is inconsistent and there is strong resistance to condom use, particularly in regard to condoms diminishing pleasure.

26. Condom use is particularly low among regular partners and thus this puts women at risk, for even if they suspect their partner has had other sexual partners they have little power to negotiate condom use.

27. Condoms are mostly associated with STDs and commercial sex; only a third of the sample knew that condoms can be used as contraceptives as well as protection against STDs; and almost half of all women report never having heard of condoms.

Health services and attendance

28. The illegal status of migrants, language and socio-cultural difficulties, plus limited finances, can inhibit them from seeking treatment or limit the quality of treatment they receive.

29. Some of these difficulties can limit their exposure to health information that may help them in diagnosing disease and in the prevention of disease

30. However, Cambodian migrants do seek treatment from the community hospital in Khlong Yai and from all health stations. Over 50% of respondents have been to the hospital.

31. Married, and older respondents are much more likely to seek treatment at the hospital than young, single respondents. Fishermen and sex workers are the least likely to go to the hospital, however, fishermen attend health stations.

32. NCA has supported STD/HIV programming through the hospital, 1993-1998. Despite cross-border collaboration with the hospital in Koh Kong there is only one regular staff in the hospital that speaks more than very basic Khmer. Some outreach and collaboration still continues but with limited resources. CARE Thailand is now working in Khlong Yai.

Summary of factors determining knowledge and risk of HIV for migrant workers.

1 From multiple regression analysis the main factors for knowledge of HIV/AIDS are prioritised in the following sequence:

Variable	Factor	Level of knowledge
Gender	Men	Higher knowledge
Place of living	within Khmer villages	Higher knowledge
Place of living	employers house	Higher knowledge
Marital status	divorced	Higher knowledge
	Widowed	Lower knowledge
Hometown	respondents from Tak	Lower knowledge
	From Phnom Penh	Higher knowledge

2 Factors determining *risk through having sexual relationships with someone other than their regular partner, are prioritised in the following sequence:

Visiting hometown	Regular visiting	Higher risk
Place of living	Staying on boat	Higher risk
Income	Higher income	Higher risk
Self-assessment of risk	High risk	Higher risk

3 Factors determining *risk through sexual relations with sex workers – prioritised in the following sequence:

Thai language	Good comprehension	Higher risk
Place of living	Staying in boat	Higher risk
Remittances	Remitting money	Lower risk
Self assessment of risk	High risk	Higher risk

*Risk here is multiple partner sex (for men it is primarily commercial sex for 2 as well as 3), so it is not necessarily high risk as in unprotected sex, although condom use was relatively low, or inconsistent, and thus we can assume a high degree of risk. The variables tested against low frequency of condom use showed no correlations.

Discussion and concluding remarks

In the Aranyaprathet report, and particularly in the final summary, there were lengthy sections on women and vulnerability, and on young men and risk, the findings here are similar. Women are vulnerable due to their subordinated role in society which provides less education and less income than men. They have less knowledge and awareness of HIV/AIDS and little power to protect themselves from infection. One difference in Trat is that there is not the same data on some of the violence toward women. Having said this it is men, at least in the early stages of the epidemic, who are vulnerable to HIV infection. And in Trat, and to a lesser degree in Aranyaprathet, there are many men, single and married, living away from their families. Despite some younger men being informed on HIV/AIDS they are still being exposed to infection from their behaviour and the risk situations in their work and social lives. The reasons why this might be so are discussed in Chapter 3.

Much of the discussion in Chapter 3 is relevant here, so there is no need to repeat those sections. Some of the discussion on men is even more poignant here, thus the discussion is taken further with a focus on risk related to masculine culture and other issues of vulnerability, which as in Aranyaprathet comes under the heading of the variability of risk and behaviour change. A major difference in the context of the two sites is that Trat is a large fishing port and so it is important to have some focus on fishermen, who have shown rates of infection from 13% to 20% in Khlong Yai (see below and 4.3).

In large part, this study is determining the degree of risk, or the potential of risk, for migrants. This is determined through how prepared migrants are for entering into a high risk situation, and in this context what are the situations or behaviours that may put them at risk. For the former the main factor is the understanding of the transmission and spread of HIV/AIDS, if they do not have a grasp of this then they will undoubtedly be vulnerable. The latter follows from this but adds further dimensions. Language, literacy, gender, education and living situation are some of the factors that may put migrants at higher risk than they otherwise might be. These variables along with other migratory variables have been tested and discussed. As stated, gender was one important variable and was discussed in length in Chapter 3. Occupation is a central variable and particularly for Trat where fishermen are the single most important occupational group. In an examination of this fishing port these two variables converge; gender, in contrast to exploring women's vulnerability as in Aranyaprathet focuses on 'male culture' or masculine behaviours, which as the findings here demonstrate are strongly associated with fishermen.

Migration behaviour and background factors for vulnerability (4.5 4.6)

In the study sample, which generally reflects the overall situation, women make up the majority in fishery related, service positions, traders, and of course, sex workers. There appears to be some demarcation with what work women do within the various industries, and to some degree, the type of industry they are employed in.

Respondents were from many areas but most came from Kampot, Kampong Cham, Koh Kong, and Phnom Penh. Approximately a third of the sample worked as farmers before migrating, with relatively high numbers of students and unemployed. Over 40% have been in Thailand for two years or longer, and just under 60% for less than two years. Almost 20% of the total sample have been in the area for six months or less.

Newcomers are vulnerable as they are more likely to have limited understanding of HIV/AIDS and of risk situations, also they are likely to have no Thai language ability. At the same time however, those who have been in the area a long time, and a substantial proportion have been in the area for a number of years, are more likely to have been exposed to risk situations. One study of 99 Cambodian fishermen in Khlong Yai found a significant correlation between those who had been infected the length of stay in the area (Entz 1999).

Most decided to migrate under the encouragement of friends or under their own initiative, with very few having agents or employers to support them. Over 40% said that they had some prior knowledge of the area before coming. Over half of the sample never visit their home town, over 20% visit once or twice a year, and the remainder more frequently. The knowledge of HIV/AIDS is greater among the latter, those that visit regularly compared to the other two groups.

The gap between male and female earnings is less than in Aranyaprathet, B3,412 compared to B3,216; however, this is clearly due to sex workers and female traders who have higher earnings. The other occupations in which women are the main employees, fishery processing and the service industry, are low paying, and generally women receive less than men in other industries.

The data suggests that many migrants are supporting families back in Cambodia. Almost half of the sample has contact with someone in their hometown and 80% of those send money home, and the majority send to parents. The frequency and amount of remittances is substantially higher than in Aranyaprathet. The difference in Aranyaprathet was that there were fewer single people, and single people were often living with their families.

While 80% of respondents had plans to go back to Cambodia, less than 25% had plans to return within the next 12 months.

Thai language (4.5)

Over 30% suggest that they can speak Thai well or moderately well, and almost 40% report that they had good or moderate Thai comprehension. There are distinct correlations with 'length of stay' and an ability to speak Thai. Those who had been in the area more than two years have much higher proportions in moderate and high levels of proficiency in spoken Thai and in comprehension. In Aranyaprathet only 20% had good or moderate speaking skills, however, 80% were interested in studying Thai. In Trat 53.5% were interested in studying Thai.

An inability to speak Thai, or to read and write, can be disadvantageous in seeking health care, which many migrants do in Khlong Yai; also in dealing with employers who are almost always Thai, and with officials where relations are often not good, and language barriers can make situations worse. Many people live in enclaves and thus minimise their dealings with Thais outside. This may limit their opportunity to increase their Thai skills, but this depends on their occupation and general contact with Thais. For instance some fishermen have good Thai language abilities but for many this may be due to having worked in Thailand. The only occupation where a correlation with good speaking and comprehension ability can be demonstrated is the service industry, primarily maids and those serving in restaurants, who have daily contact with Thais.

Health services: access and difficulties (4.2 4.3 4.11)

Over half of Trat respondents reported having been to a Thai hospital, primarily this is the local community hospital in Khlong Yai. Most of those who had not been had never required medical services while in Thailand. This contrasts with only 12% of Aranyaprathet respondents having attended a hospital. In addition, health stations are frequently used in all three sub-districts in Khlong Yai District. The difference is that almost all migrant workers reside in Khlong Yai, rather than commuting, and there are established communities. Relations between Thai and Khmer appear to be better, partly due to the 'Thai Koh Kongs' – Thais who used to live in Koh Kong in the past and are bilingual.

Those with high incomes, over B6,000, were slightly more likely to visit the hospital which is some indication that price is a concern, and price was mentioned by 20 people, 5.8%, as a constraint in seeking treatment. A similar proportion mentioned language as a concern and considering that most do not speak Thai, and very few read or write, and the hospital has only one person with more than very basic Khmer, it will undoubtedly be a problem. The outcome is not only difficulties with having effective treatment but receiving health information.

Fishermen are least likely to seek hospital services, there may be a range of reasons for this but they do appear to visit the health stations. One official at a health station said that fishermen were frequently coming for STD treatment only a year or two ago. It was not possible to confirm this as hospital officials were adamant that the number of STD cases has been small for some years. However, STDs are a concern in Koh Kong and some fishermen are no doubt infected, and it is likely that the best treatment they could receive would be from the Khlong Yai hospital but they are obviously self-treating or being treated in Koh Kong. Sex workers are the other group that are least likely to seek hospital services, and this is of concern for the same reasons. More research is required to determine the extent of STDs and where people seek treatment, for STDs could be a major determinant in the rate of spread of HIV in the area if not checked.

Koh Kong has much higher rates of HIV infection than the national average of Cambodia, and of course the rates are considerably higher than Khlong Yai, which in fact is relatively high for Thailand (see 4.3). In Koh Kong 80% of infections are reported to

be through heterosexual sexual contacts and 7.3% through injecting drug use. Six people in the total sample admitted to injecting heroin and sharing needles, this may under-represent the actual proportions of fishermen or others who are injecting drugs.

Migrant workers have high rates of infection as well, with fishermen the highest, in 1998 11% of 876 migrant workers tested positive for HIV, this included 13% of 436 fishermen positive. Another study of fishermen in Trat, with a sample of 99, showed 19% positive (Entz 1999).

The hospital at Khlong Yai has in fact been doing outreach work and providing materials in Khmer language and working with the staff from Koh Kong hospital. They have been funded from Norwegian Church Aid over five years, from 1993-1998. Now they have very little budget to undertake any of these activities. They may be provided with some support from CARE who are now working Khlong Yai.

HIV/AIDS knowledge and attitudes (4.7/8/9/10)

As is discussed below, knowledge of HIV/AIDS does not necessarily change behaviour. This is particularly true of prevention and safer sex practices. But it is also true for attitudes toward PWHA. The fear that people harbour for PWHA is logical given a limited understanding of the spread of disease, and their traditional beliefs in regard to contagion. However, knowledge and greater awareness can help in overcoming the misconceptions that people have in the casual transmission of HIV. If people are keenly aware of how HIV spreads then they are aware of how it doesn't spread, and therefore may not be so fearful of PWHA.

Women in Trat have less HIV/AIDS knowledge than men and express more fear toward PWHA. And yet women may take on a disproportionate share of the burden of looking after people when they fall ill from AIDS related conditions. Of course, what they have expressed here are their own projections, their more practical and compassionate instincts may overcome fear just as much as knowledge can. However, if they are prepared with greater awareness this can lead to genuine concern and support without the fear of contagion, and assist in reducing stigmatisation in the community. This is extremely important in this border region where already considerable numbers of people are falling ill and dying.

Trat respondents actually had more positive attitudes to PWHA than those from Aranyaprathet and they were far less likely to think that HIV can be transmitted through casual contact; however their general understanding and awareness of HIV/AIDS was still quite low.

Trat respondents had much lower responses than those from Aranyaprathet on the main ways that HIV is transmitted and they were more likely agree with some practices and beliefs that are potentially very risky practices. In addition, they were far more likely to support the idea of men having extra-marital and pre-marital sex, including that with sex workers.

Low income and low education is associated with inadequate understanding of HIV/AIDS transmission and spread; and low education is associated with certain beliefs and attitudes that potentially lead to high risk behaviours; however, such attitudes can be found across all income and educational levels.

Women have low education, 3.15 years compared to men, 5.72 years; and low income (see above); and they low HIV/AIDS knowledge. This is clearly a factor in determining that women are vulnerable to HIV infection. Another factor is that they have little negotiating power in using condoms with their partners, whether they be casual or regular sexual partners.

Fishermen and the culture of risk

Many of the behaviours and attitudes which might be apportioned to fishermen here are not necessarily unique to fishermen; the data attests to this through similar findings across occupational groups. However, fishermen represent an occupation where men spend long periods of time together in the absence of women. Other occupational groups, including some migrant workers, may have similar experiences, and sometimes military personnel might spend long periods of time with men only. At the same time it is different for fishermen, and a sub-culture that can be identified in various ports attests to this. Even if some men do not spend a long time at sea, perhaps they more commonly have duties on shore, they can still participate in the same activities that many fishermen indulge in. Weeks or months at sea can bring about a lot of pent up energy that is released on shore. Fishermen now have a reputation for a big spend up on their return – gambling, drinking together, and visiting sex workers. Sex workers take advantage of this situation and converge on port areas.

Apart from the pent up sexual energy there are other factors that give rise to this behaviour. Fishermen can be quite well paid, especially through a bonus system, and they receive this on their return. Thus, their urge may be to spend without thinking of the future, or their family for that matter. It is of course easier for young, unmarried fishermen, with less obligations, who can work just for spending on their shore leave. One young man in Trat, who had been fishing for some years, expressed such sentiments. The other side of the issue is that saving money is physically difficult, especially if there are few people that they can trust and there are no institutional facilities for saving. Some companies have instituted systems of paying so that the wives or families receive the money, or some of it, directly (see accompanying report on Myanmar).

So what is often seen as squandering money can be just that, but it can also be due to limited alternatives of what to do with their money. It is not necessary to condemn or stigmatise fishermen for what may seem as frivolous lifestyles. They are like many other migrants who in the face of difficulties and vulnerabilities adapt as best they can to the situations they find themselves in. Some fishermen may have chosen the occupation because of the reputation it has gained and perhaps being attracted by a sense of adventure. Others may have entered the business inadvertently and adopt or follow the customs and habits of their peers. Nonetheless, it is important to further the discussion on

gender issues, especially that related to 'male cultures' that may give rise to sub-cultures. Before, looking at aspects of such cultural attitudes and behaviours it is necessary to summarise the socio-economic factors.

In the Aranyaprathet summary issues around knowledge of HIV and its relation to behaviour change were raised, now this discussion can be taken a little further. Fishermen were found to have higher knowledge than other groups, this was a finding in Ranong as well (see Myanmar report). Thus, it may be said that while knowledge is the foundation for behaviour change it is not necessarily the impetus for behaviour change. This is the very reason innovative programs that use participatory approaches have come into being. The rationale is that people must internalise the understanding of risk, and just providing knowledge alone there may be little motivation for reflection and a deeper understanding. But this is just one dimension of the challenge in behaviour change. Other factors that can be directly related to fishermen include the notion of risk, which can be twofold. Firstly, fishermen are participating in a risky occupation and AIDS is just another risk to factor into their lives. Secondly, a related notion is that they are not averse to risk, and as part of the 'male culture' they accept risk as part of their life as a man and perhaps perceive risk situations as a test of their strength and 'invulnerability'. This is perhaps attested to in the men who see it as courageous, in a masculine way, to not use condoms – a test of their invulnerability.

The other aspect of the challenge to programmers in behaviour change is the difficulties of working with a mobile population, such as migrants, and particularly fishermen. There have been programs in Ranong, conducted by World Vision, for the past six years, and as noted, fishermen and sex workers are well informed on HIV/AIDS through innovative and participatory approaches, however, high risk situations still exist. This indicates the difficulties in attempting to implement effective programming. High risk is usually defined as unprotected sex, and fishermen are more likely to use condoms than other groups; however, in a context of numerous partners over one year where high condom use is not the norm and correct use of condoms is not common, the risk situation can be high. Some of the practices, discussed elsewhere and below, preclude the use of condoms, which indicates that substantial numbers of fishermen are not using condoms consistently.

To return to the 'variability of risk', as it was discussed in Aranyaprathet, while the data shows correlations with low income, low education and low knowledge of HIV/AIDS, and thus vulnerability to HIV, other groups can be vulnerable as well. Attitudes and misconceptions that may make people vulnerable, and actual risk behaviour itself, can occur across education and income levels, but more importantly, higher incomes can lead to being vulnerable also. A greater disposable income, as has been shown to some degree with fishermen and their spending sprees, can lead to greater opportunities to spend, which may lead to more entertainment and more drinking and higher risk behaviours.

This leads into the discussion on male culture or masculine behaviours. A symbol of manhood is being able to court and win the heart of a woman, a form of rite of passage. This may be seen as a form of conquest, to 'bed' a girl or woman. The *kheun khru* custom

has become a rite of passage for some young men and perhaps this feeds into the notion of conquest and manhood. Furthermore, men may compete amongst themselves to see how many hearts they can win. In Thai society there appears to be some value attached, among men at least, to having more than one wife, or more than one girlfriend. In the variables on masculine behaviours and on sexual norms, fishermen were more likely to agree with the practices and beliefs that are potentially high risk. In addition, men in Trat were more likely to agree with unmarried men having sexual relations, either commercial or non-commercial sex than in Aranyaprathet. And men in Trat were much more likely to find it acceptable that married men might have such relationships. Fishermen are predominant, but it is other men too.

The fishing sub-culture is built around masculinity and male bonding. In some areas it is common that captains pay a bonus to their employees partly 'in kind', that is, they pay for a night out visiting a brothel. It can also be common that men have pornography on board the boats, and if they have free time discuss sex, and then some go as far as incising marble into their foreskins, or injecting oil into their penis to make it larger. These activities are designed to stimulate their sexual partner, and by doing so enhance their own sense of self as sexually virile.

In summary, risk is variable, it may be enhanced by income and prestige, and at the same time it may be enhanced by low income, which is coupled with low education and low HIV/AIDS awareness. While the latter situation may be the case for most migrants, as demonstrated by the findings on HIV/AIDS knowledge and awareness, the former is likely for others, such as fishermen who are among the higher paid occupations. Migrants become vulnerable because they are not prepared for moving into a high risk situation which this border is, and many other border areas are. They are only one section of the border population which includes locals, police and soldiers, tourists, traders and other business dealers, but they are generally the most vulnerable. Among their numbers are women and girls who are trafficked, tricked, and come voluntarily to work in sex work, the latter may be the most common now. Some may come to do other work and discover that they cannot find work, or cannot earn sufficient money, and enter the sex trade.

Risk situation, sexual relations and condom use (4.1 4.8 4.9)

Income and prestige that allows for greater opportunities in entertainment and using commercial sex work is prevalent among other groups, other than fishermen or other migrants such as traders. Local officials, including uniformed men, tourists, businessmen, visiting officials and others appear to be attracted by the illicit opportunities available to them in border areas. In Trat this includes men on both sides of the border and those crossing the border. Some informants thought that Thai men did not regularly use Cambodian sex workers, at least not in Khlong Yai, however, other respondents said that there were regular Thai clients. And just beyond the casino informants assure us there is an area where direct sex workers provide services primarily for Thais crossing the border.

However, within this context it is the port areas where commercial sex work has arisen to provide services for fishermen. Of course, this is not just because fishermen are more frequent users, it is partly due to the size of the fishing industry and the sheer numbers

involved. There are two major sites in Koh Kong in which Cambodians are the predominant customers, and then there is Koh Kut and other islands, as well as Khlong Yai where large numbers of sex workers are found. Women it seems often move to where the greatest numbers of fishermen are at any one time. This suggests that they are dependent on fishermen, but this should not detract from the fact that large groups of other men take advantage of the port areas to avail themselves of sex workers.

Both single and married men, over 60% of all men, report multiple commercial sex contacts in the past year, with as many as 30 or more contacts for some men. Those who had more than 15 commercial sex partners predictably are among higher income earners, in addition they have a higher education than most. They are mostly fishermen or saw mill employees.

For just over 50% of men, mostly single, their last sexual contact was with a sex worker. Fishermen are more likely than other groups to admit to having had sexual relations with sex workers. In reference to visiting sex workers over the past year only 59% say that they always used condoms. For most men, 80.9%, the first time a condom was used was with a sex worker.

Only 23 women admitted to having sexual relations with a person outside of their spouse or regular partner, with 18 out of 23 saying that they would never use condoms, 14 of them are married. This is an indication of low use in non-commercial sexual contacts and is consistent with many other studies where condom use outside of commercial sex is very low (see Chapter 3). This is the clearest indication of sexual contacts outside of marriage as married men gave their last sexual contact as 77.5% with their spouse and 17.5% with sex workers. Of all single men 81.6% report a sex worker as their last sexual contact, and 11.3% a girlfriend, and 7.6% a casual partner.

The above data may not represent the amount of sexual networking that occurs, and it is clear that what is occurring is within a context of most men visiting sex workers, inconsistent condom use, and high HIV prevalence. There is strong resistance to condom use in commercial or non-commercial settings, some of the reasons have been discussed in the text of this report – customer dissatisfaction, being drunk, cost. Other considerations are that condoms break, and they may be taken off during intercourse. In non-commercial sex the main difficulties are that condoms are association with STDs and sex work, and that women have little negotiating power with their partners (and see the summary in Chapter 3). More research is needed to determine what are the main determinants causing non-compliance but all of the above factors should be considered in programming.

Only six people admitted to injecting drugs and similar numbers admitted to having used other drugs in the past. While fishermen have been known to inject drugs in the past according to this study and other reports on Trat and Koh Kong there is limited evidence of wide-scale usage today, but this should be explored further. Fishing vessels, however, can be used for smuggling goods and there is evidence of marijuana and amphetamines being smuggled in the area. The Koh Kong report mentions that some fishermen felt that

the drinking water was laced with amphetamines (UNICEF 1999). Similar stories emanate from Ranong where food may be laced with amphetamines, but where use is reportedly common among Thai and Burmese fishermen, as well as Thai truck drivers. It is reported also reported in Ranong that other non-prescriptive drugs from the chemist are also commonly taken in tablet form (UNICEF 1999). Most of these drugs tend to dampen sexual desire but if sexual relations occur they may induce unsafe sex practices.

Alcohol is the most widely taken drug and clearly places people at risk through men bonding together by drinking with their friends and then feeling the urge to complete their eating and drinking together rituals with sex. Sex workers report that most customers have been drinking and that those who are drunk may not use condoms, or if using condoms may take too long which can induce the sex worker or the customer to remove the condom.

The above summary suggests that there is some urgency in establishing HIV/AIDS programming in this area of high HIV prevalence. Women and men do not appear to be acknowledging the risk that faces them, and knowledge and general awareness of how HIV spreads is not well understood. The CARE program in Khlong Yai is trying to change this situation, but the experience of Ranong suggests that in port areas, where the risk situation is high, changing the socio-cultural patterns and norms is very difficult. Local and transient populations from both countries are at risk, particularly with many port areas in the region, however, the vulnerability of fishermen is particularly high, and this places the community at risk, including female commercial and non-commercial sexual partners of fishermen, and other sexually active people in the community.

Recommendations

These recommendations are to be noted as guidelines for organisations that are involved in implementing and designing programs in Khlong Yai. The focus of the interventions are for migrant workers which include a range of occupations, but the main occupation is fishing with the associated industries of processing and transport. The illegal status of migrants must be considered with the design and implementation of activities. Recommendations on such issues appear in Chapter 5.

It is evident that Thai population groups are at risk also from the spread of HIV in this border region. On both sides of the border there is a high HIV prevalence among sex workers, many of whom service Thai clients. On the Cambodian side the military and police have very high rates of HIV infection, and it is likely that members of the Thai police force, the military, and immigration officials, as well as other mobile groups are vulnerable to infection.

Migrant workers are known to be vulnerable for HIV infection and the following recommendations focus on how to reach, inform and mobilise the different occupational groups, taking into account such factors as age, education and literacy, gender and other factors pertinent to these groups. However, the risk situation is commercial sex in

particular vicinities and sexual networking, thus risk exists as part of the community that supports, and participates in, the entertainment and service industries. In addition, through sexual networking it goes out into the wider community, thus creating a community problem that requires community respsonses. Drug use exists in the community as well and this could provide further risk. The following are a range of suggested responses to target vulnerability in migrant communities and in general to mobilise the community in establishing appropriate responses to the spread of HIV and to the care and support of PWHA.

1 Formation of a local working committee

At the district level a working committee can be established to coordinate activities. Problems within the migrant community within the environs in which they work in Khlong Yai can be discussed, along with strategies to improve or develop health and HIV/AIDS services and preventative practices. All relevant government agencies, including health, immigration, police, labour and social welfare should be represented in the local committee, along with any other agencies supporting, or implementing, programs in Khlong Yai. Migrant representatives, and if possible employer representatives, should also play a major role in the committee. If possible the committee should be linked to provincial and central bodies but have sufficient autonomy to respond to local needs and implement interventions. The initial impetus may come from a re-activated local AIDS committee but this may have to give way to a broader, more representative committee.

2 Organising local workshops

As an initial stage for the formation of the proposed local committee, a workshop can be organised in Khlong Yai involving all individuals, organisations and agencies that will support and participate in the local committee. The workshop should include representatives from the Koh Kong. The main item on the agendas would be the findings and recommendations of this study, and any other local studies could be included. This will be a means to provide important feedback on findings and discuss some of the pertinent issues. This can be followed by discussion on possible funding arrangements and the structure and function of the local committee. Discussion on possible activities can follow with the outline a proposed work plan.

3 Employers

Migrants are generally employed in businesses and industries that are in the private sector. Thus, the private sector should be encouraged to participate in discussions that are exploring strategies to improve health care for migrant workers. Meetings with employers, officials and other stakeholders must be balanced discussions, taking into account that employers are interested in profits. Employers can be made to realise that they have something to gain through working with government to develop effective health strategies. For minimal output they can maximise input from workers through a healthier workforce with less days off due to illness.

4 Programming in Khlong Yai

From the findings it is possible to identify the most vulnerable groups, and through identifying them and working with them it is possible to enhance protective behaviours. The approaches however, must be comprehensive, so that the whole community acknowledges the problem and many individuals, groups and institutions see the need to take some responsibility for cooperative efforts to improve the situation. The following suggestions cover many of the findings of this study.

- Gaining cooperation from Thais employers to access workers - this may include large and small companies as well as the captains and foremen of boats. It can also include entertainment areas.

- Targeting family groups - which may assist in reaching women who generally have low HIV/AIDS knowledge, as well as married men who had lower knowledge than single men. Women have low knowledge and for other reasons are vulnerable to HIV infection. They can be targeted through special leaflets, posters and other media materials, and through special venues, such as health stations.

- Peer education and special media materials with different themes can be used for different groups, for instance, for fishermen the focus might be on condoms and reflection on one's own risk, rather than just on knowledge and general awareness.

- Condom distribution is crucial for fishermen and other men who use commercial sex, and for sex workers themselves. This needs to be followed up with precise messages on the necessity of always using condoms and emphasising the correct use. Social marketing can accomplish this in part, but it should be an essential part of all training and media materials.

- Exploratory research could be undertaken also to determine when seasonal work begins or if there are particular periods, or ways of determining when there are many newcomers who should be exposed to information on HIV/AIDS.

- As an adjunct to the above point migrants could be reached prior to their movement across the border and provided with information. The possibility of establishing networks to provide pre-departure information on conditions on the border and HIV/AIDS knowledge prior to migrating could be explored.

- Cross-border collaborative projects should include the development of IEC materials in Khmer language pertaining to STD/HIV/AIDS, and other health problems, which can then be disseminated on both sides of the border.

- Training should be offered to border officials and police, as well as military, on the situation of HIV/AIDS on the border and the necessity of all mobile groups being

informed on safer sex practices. Cooperation should be sought from representatives of these groups for comprehensive programming in the area.

5 Community mobilisation and an enabling environment

Effective programming is dependent on community involvement, for only through community participation can an enabling environment evolve. This can first be approached through more settled villages among fishermen and their families. However, a true enabling environment it requires a civil society approach where all organisations and institutions are stakeholders in the benefits of improved community cohesion and well-being.

Some of the findings of this study show that there are many misconceptions regarding the transmission and spread of HIV. Other findings suggest that knowledge alone does not lead to behaviour change. The following guidelines for effectively working with and mobilising the community are drawn from many years of programming elsewhere, especially in Thailand, and can be tested and modified to suit the situation in Khlong Yai. Some communities may not be clearly defined as migrant workers as workers may sometimes be only part of a community, or they may be small community of only workers, attached to a factory or saw mill, fishermen who live and work together. Programming can target particular groups, as a community in themselves, while at the same time seeing the broader community as a focus for longer term changes.

- The first steps in community mobilisation are Steps 1 & 2 above, but no time must be wasted in bringing these plans and proposals down to the community level and testing ideas in the field through practical sessions with the migrants themselves. PRA activities are one way of doing this and can be one of the initial steps in designing programs.

- The potential for peer education strategies can be explored among occupational groups, for example, sex workers or porters/labourers; and among village groups, for example, housewives or teenagers; and among shrimp farmers or on rubber plantations, where the findings show that low income and low education can lead to limited knowledge and awareness. This approach can be developed through participatory approaches such as inventive training programs, PRA/PLA activities, or life-skills programs, which are widely used and have proven to be effective in Thailand.

- Peer education and/or participatory approaches, such as PLA can be used for a range of community groups – the community is the focus and not just fishermen or sex workers. Peers here may not only educate but support behavioural changes, as part of building an enabling environment.

- Training and PLA can be used throughout the community, this includes all groups – from high officials to soldiers and service workers and many more. The first step is

informing people of the severity of the problem and the means to deal with it. The high prevalence of HIV in Trat and just across the border indicates that HIV is spreading through sexual networks beyond sex work and thus it is a community concern that must be dealt with at the community level.

- Integrated programming, of which there are many examples, but one example could be literacy and/or health programs for women which include a component on HIV/AIDS. It could be income generation for women which includes HIV/AIDS programs. Such programs may help to build awareness among women which is lacking according to the findings, and also to reduce vulnerability through making them more self sufficient.

- All pharmacies and private clinics can be targeted and provided with up-to-date information on STD treatments and the situation of HIV/AIDS. This more relevant to Koh Kong where the government should be encouraged to upgrade the basic medical services to deal with HIV/AIDS, which may soon be a major issue in care and not just prevention, as people fall ill.

6 Cross-border collaboration

Exchanges between any health sectors on both sides of the border can assist in providing information materials, distribution of condoms, and other prevention and care activities. This has already occurred between the hospitals but requires further support. For example, provision of materials in Khmer language should be available on the Thai side. Cross border collaboration does not have to be the beginning and end. The means to effective collaboration may evolve over time as programming develops on one or both sides of the border, arising out of identifying areas of need that can benefit from exchanges of information and regular communication.

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

CHAPTER 5

Summary of Thai Cambodian Border Situation

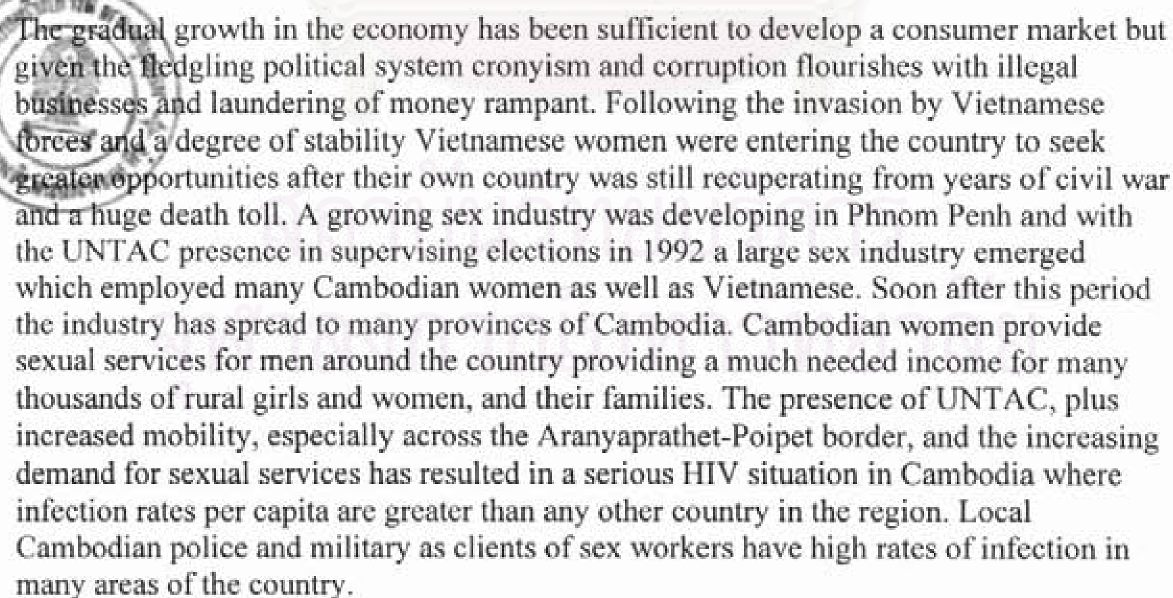
5.1 Comparative Analysis of the Two Sites

Cambodia: past and present

Cambodia is still in the process of returning to political and social stability after decades of instability due the upheavals of a civil war that resulted in millions, either dying, or fleeing the country to ultimately live for many years in refugee camps. Ongoing skirmishes in many parts of the country, due to ongoing conflicts with the Khmer Rouge, plus political power plays from Phnom Penh, have provided little security and hope for the population which still mainly resides in rural areas.

There have been many difficulties in the repatriation of tens of thousands of refugees, partly because of the widespread destruction of rural communities during the Pol Pot regime. The loss of community structures and community spirit, and the demographic change due the deaths of more men during and after the war has made it difficult for many former refugees to settle. Many of those repatriated over the past few years have not been able to settle successfully and have joined others in seeking work opportunities outside of Cambodia in recent years.

During the times of social and political upheaval the economy was stagnant. Economic expansion has occurred slowly over the past 15 years, with a very gradual filtering down to the countryside. While economic expansion has been slow in Cambodia its neighbour, Thailand, has had one of the fastest growing economies in the region. Thus, Thailand has become a favoured destination for migrants seeking work, either in the border region or further inside the country. The recent economic crisis slowed the stream of workers entering Thailand but less so in the border region than elsewhere in the country.



The gradual growth in the economy has been sufficient to develop a consumer market but given the fledgling political system cronyism and corruption flourishes with illegal businesses and laundering of money rampant. Following the invasion by Vietnamese forces and a degree of stability Vietnamese women were entering the country to seek greater opportunities after their own country was still recuperating from years of civil war and a huge death toll. A growing sex industry was developing in Phnom Penh and with the UNTAC presence in supervising elections in 1992 a large sex industry emerged which employed many Cambodian women as well as Vietnamese. Soon after this period the industry has spread to many provinces of Cambodia. Cambodian women provide sexual services for men around the country providing a much needed income for many thousands of rural girls and women, and their families. The presence of UNTAC, plus increased mobility, especially across the Aranyaprathet-Poipet border, and the increasing demand for sexual services has resulted in a serious HIV situation in Cambodia where infection rates per capita are greater than any other country in the region. Local Cambodian police and military as clients of sex workers have high rates of infection in many areas of the country.

Table 5.1 Comparison Between Aranyaprathet and Trat (Khlong Yai) Border Areas

ISSUES	ARANYAPRATHET	TRAT
Migration situation		
Migrant workers (est.)	4-5,000 + adjoining districts	3,000 most in port area
Living location	Most commuters & on farms	Villages/employer housing
Occupation/environs	Farms/labour/busy market	Fishing port/industry
Living situation	More with family	More men away from home
Remittances	Less send, small amounts	More send, substantial sums
Legal status	Commuters & illegal	Illegal, some registered
Length of stay	Short & long, more short term	Short & long, more long term
Relations with Thais	Separate/not close	Closer, more amiable
Returning to Cambodia	70% no immediate plans	80% no plans for 12 months
Thai language	20% can speak	30% can speak
HIV Risk situation		
Risk area for migrant	Mainly across border	In Trat and across border
HIV prevalence	High in Poipet	Very high in Koh Kong Relatively high in Trat
STD prevalence	High in Poipet	High in Koh Kong
Sex workers	Several 100 in Poipet, sent nightly to Aran and returned	100s in port enclave K.Y. 1000 in KohKong & islands
Commercial sex	Bars/brothels in Poipet	Bars/brothels – all port areas
Context/clients	All mobile popns,Khmer/Thai Including uniformed men	Fishermen, other men, mostly Khmer, incl. Thai
Condom use – CSW	Inconsistent among Cambodians (Thais use more)	Inconsistent negative attitudes
Casual sex	Prevalent (low condom use)	Prevalent (low condom use)
Drug use	Not detected/smuggling	Some fishermen use
HIV/AIDS awareness		
Transmission	Misperceptions casual contact	Misperceptions risk practices
Attitudes to behaviour	Accepting some risk practices	More accepting of high risk
Attitudes to PWHAs	Misconceptions and fear	More aware, little less fear
Sex workers	Limited – MSF now assists	Limited – CARE assisting
Women	Low awareness (low educn.)	Low awareness (low educn.)
Health services		
Utilise services in Thai	Limited, mainly health station	Regularly use station/hospital
STD services	Go to Poipet – clinics, MSF - - resistant strains present	Fishermen likely self-treat - unlikely attend K.Y.hospital
STD/HIV education	Limited on Thai side MSF in Poipet	Previous support NCA Now CARE in Khlong Yai
Care of PWHAs	Non-existent or limited	Hospital support, limited
Condom distribution	Free distribution in Aran Social marketing Poipet	Free distribution in K.Y. Social marketing Koh Kong

The study sites

This study has explored some of the many factors that can lead to vulnerability, starting with demographic and migrant behaviour variables. There are some variables where there is a high correspondence in the findings of both sites, but there are some that vary, sometimes quite substantially. These parallels and differences provide interesting insights into migration and mobility in Cambodia, as well as awareness of HIV/AIDS and findings on attitudes and risk behaviors. Table 5.1 clearly presents a comparison of the two sites and the following discussion elaborates on the differences and similarities. For further elaboration refer to the summaries in 3.12 and 4.12. In addition, throughout the findings section in Chapter 4 on Trat many comparisons are made with Aranyaprathet, especially in the summaries after each section, which often include tables for comparison.

Aranyaprathet has been in the centre of many skirmishes during fighting in Cambodia, and borders at both sites were crossed by many thousands during the civil war in the 1970s. Aranyaprathet has always had a strong military presence and has a military hospital. During the civil way many people fled across the mountains into Trat, and the province has been the home to major refugee camps since. Many refugees were only resettled in May of this year.

Borders in both areas are porous, in Khlong Yai this is because of the bay and the many boats that can easily transport anyone to ports along the long coastline. Also it appears that many people receive border passes but over stay their passes. In Khlong Yai, Trat, many people once lived in Koh Kong and thus can move back and forwards to visit relatives or do business, therefore along with other traders and travellers there are continuous land and sea crossings across the border. Aranyaprathet is separated by a small canal, which can easily be crossed, and locals appear to pass this way in sight of the immigration check point.

Aranyaprathet has no major industries apart from agricultural products whereas Trat has had many timber processing mills up until this year, and has a major fishing industry. Sawmills are virtually all closed and the future for most of them seems bleak. Fishing however, is still a mainstay for the economy of the area and has integrated processing and transporting of fish products from across the border to markets in Bangkok.

Aranyaprathet is a major market area, attracting people from Bangkok and many other areas, and acts more as a thoroughfare for trucks and other business than Trat does, even though it is a destination point for most people. There are many sex workers in bars and brothels in Poipet who service Thais on business, tourists, or officials, in addition to many Cambodians. They are also transported across the border daily to service mainly Thai clients. This area has been the site for trafficking of women and is reported to be well known for smuggling drugs and other goods. Risk factors for HIV infection also exist on the farm areas where sexual networking, including Cambodian women selling themselves, and violence toward women reportedly occurs. Condom use is generally low or inconsistent and the knowledge of HIV/AIDS is limited with many misconceptions.

In Trat the port area is comprised of village communities of mostly Cambodian migrants. There are 'red light' zones here that cater mainly for fishermen but many other men as well. Thus, migrant workers are within Thai precincts and many utilise health services within Khlong Yai. Fishermen, of course, are very mobile, and so are sex workers. Both can be found in sites just across the border in Cambodia. They are also found on local islands. Unlike many other migrants they are unlikely to seek health care at the Khlong Yai hospital, either going to private clinics or self-treating in Koh Kong, or for fishermen, out at sea. Vulnerability to HIV infection occurs through limited understanding of HIV transmission and spread, but also through multiple partner sex, primarily commercial sex, in a context of inconsistent use of condoms. Higher incomes, such as that of some fishermen, and other groups, allows for greater opportunities and enhanced risk.

Legal status

Over recent years there appears to have been more enforcement of Cambodians moving illegally into Aranyaprathet, thus most workers are commuting daily, with official border passes at the immigration check-point, and through being signed in by employers on several special crossings along the border. The only migrants that live in Thailand are those on farms to the north of Aranyaprathet and in adjacent districts. They provide cheap labour for local employers, come and go according to the seasonal work available. There were very few registered employees in Aranyaprathet so they are vulnerable to harassement and have little in the way of health service or other facilities available to them. Registration procedures will not help daily commuters who often suffer from the same problems of inadequate health provision and no social welfare.

In Trat the situation was very different with migrants living in some settled communities or in employer provided housing in Khlong Yai. Some also have work permits through the employer registration system, which includes some fishermen. However, this still leaves most of them vulnerable to police crackdowns which have been increasing, even people who have been settled here for some years. As in Aranyaprathet workers are paid less than Thais, they are not eligible for health or welfare benefits. The Thai government is attempting to provide some services to the migrants in the revised registration system. This has the potential for improving their living conditions and access to health care. But these issues are largely unresolved and the past and current crackdowns on illegal migrants will undoubtedly continue, exposing many migrants to abuses with little or no acknowledgement of basic human rights.

Migration situation

Many migrants are daily commuters in Aranyaprathet, approximately half of the migrant workers cross the main immigration check-point in the busy market area and are employed in a range of occupations. There are also seasonal workers who cross daily at several small check-points and further inland there are others who migrate from home, or from site to site, periodically and reside in Aranyaprathet or in ajoining districts. In Trat

while there are many fishermen living on boats, and other single or married men living in single accommodation, there are settled villages in the port area where many Cambodian migrants live and work. The proportions of married and single respondents are relatively equal in Trat whereas in Aranyaprathet single people only make up 39.3% of the sample, but most of these were single men. There are more married men in Trat living away from home than in Aranyaprathet.

In both sites women were less educated than men and had lower incomes generally than men. Education levels were higher in Trat than Aranyaprathet. Women comprise only 31.5% of the sample in Trat compared to 42.5% in Aranyaprathet. The higher proportion in Aranyaprathet reflects the existence of more family groups, particularly as there were fewer single women in Aranyaprathet.

Many workers in both sites were earning between B60-B100 per day or B2000 per month, however, this was true of 80% of workers in Aranyaprathet and 40% of workers in Trat. In Trat and Aranyaprathet traders had the highest income, with a mean of almost B12,000 per month in Trat. Sex workers had a mean of almost B6,000 and fishermen B4,000. Fishermen, as a group, had relatively high income but many were small income earners as well.

The higher earnings in Trat are reflected in higher amounts of remittances. Individuals were remitting far more money than respondents in Aranyaprathet, and there were more of them as there are many single men in Trat who appear to be supporting parents back home.

There was stronger demarcation between what women did and what men do in Trat, whereas in Aranyaprathetyaprathet men may have taken the heavier jobs, particularly in labouring, but generally in agriculture they worked together as couples or in family groups.

In Trat there is a significant correlation with length of stay and an ability to speak Thai. This reflects the different situations where in Trat migrants live in Thailand whereas in Aranyaprathet most of them are commuters.

HIV/AIDS risk situation

If comparing the border provinces with the national prevalence rates in the respective countries it is clear that prevalence rates generally are high, and they are generally higher in the provinces across the border in Cambodia, especially in Koh Kong but also in Poipet.

Like many border areas illegal activities and prostitution are common. The sex industry in Trat has arisen from the existence of many fishermen. In Khlong Yai, Koh Kong and nearby islands, fishermen continually go out to sea and return days or weeks later in search of 'rest and recreation'. In Aranyaprathet the large military presence has helped to give rise to the sex industry but in recent years of economic growth tourists, traders,

business people and uniformed officals, and others support the sex industry. In both sites there is a wide range of men, from migrant workers to local and visiting officials who patronise sex workers. While many brothels have closed down in recent times in Thailand the numbers of Thai sex workers has diminished being almost entirely replaced by Cambodian and Vietnamese sex workers. In Aranyaprathet the sex workers reside in Poipet and service customers there but are transported across the border each night to service mostly Thai clients. In Khlong Yai there are many sex workers servicing mostly migrant workers within Thailand, but then there are many sex workers across the border and on the islands and there is a rotation of workers from site to site.

Condom use

Condom use is inconsistent in commerical sex, and lower than elsewhere in Thailand, except for other border areas (see accompanying report on Myanmar). In both sites findings show that condom use is lowest among Cambodian sex workers compared to Vietnamese sex workers, and Cambodian male clients rather than Thai clients.

There is evidence of sexual violence in Aranyaprathet and for commercial sex this includes sex workers having to have up to 20 customers at one time, and virgins being deflowered. In these instances condoms are never used or very inconsistently. Other abuse occurs on the border by uniformed men or on farms by other migrants, again situations where it is likely that condoms will not be used. Findings of the study are consistent with many other reports that suggest condoms are not used in most non-commercial sex. Thus women can be at high risk from their spouse or regular partner, and yet few women in either site acknowledged this risk. Furthermore, there is some evidence of what might be extensive sexual networks beyond commercial sex.

Drug use

Injecting drug use has been common among some fishing communities in the past; however, according to this study and other reports on Trat and Koh Kong there is limited evidence of wide-scale usage of injecting drugs. Both sites reportedly have been areas for smuggling drugs, currently, marijuana and amphetamines appear to be common. There are reports of amphetamine use on fishing vessels but most reports refer to inadvertant use through employers lacing food or drink. Alcohol is the most widely taken drug and clearly places people at risk through increasing the likelihood of unsafe sex practices. There is a need to do further qualitative research on all types of drug use.

HIV/AIDS awareness

The knowledge and general awareness of HIV/AIDS is low in both sites. In Aranyaprathetyaprathet most people understood the main routes for transmission of HIV, in Trat far fewer respondents were clear on these routes of transmission. However, Trat respondents were much clearer on how HIV is not transmitted, that is in casual contact (4.7). And yet attitudes toward PWHA tended toward fear in both sites for a great number of people (4.10). Misconceptions on prevention were more prevalent in Aranyaprathet

but accepting attitudes to what are potentially high risk behaviours were more prevalent in Trat (see summaries in 4.7 & 4.8).

Correlations of low awareness with women, young people, low income, and low education, highlight issues of vulnerability among migrant groups. Low rates of literacy in Khmer as well as Thai add to their vulnerability, and suggests that many migrants are ill-prepared for entering into an environment of high risk (4.6 & 4.7). Also people who have been in the area a short time will have limited knowledge and understanding of the spread and transmission of HIV, which can put them at risk.

Health services

The Khlong Yai hospital treats as many migrants as it does Thais, and from 1993-1998 was funded by NCA to do training and outreach work on HIV/AIDS, and this included some collaboration with the hospital in Koh Kong. Koh Kong has more basic services than what is available in Khlong Yai. Communicable diseases including some STDs are much more prevalent. CARE Thailand now has an office and HIV/AIDS program in Khlong Yai.

In Aranyaprathet the hopsital has been funded for some years to treat refugees from the refugee camps. Now it is treating some migrants but mostly migrants who are more wealthy and can afford to pay. Some migrant workers seek treatment for minor ailments in the health stations near the border. As most are commuters they generally seek health care in Poipet where there are government and private clinics. MSF reportedly receives many patients seeking STD treatments, and many of them have been unsuccessfully treated elsewhere before visiting MSF.

Future and current activities

For most respondents after work recreation is mainly in the form of watching television, just staying at home, or visiting friends. Entertainment, drinking, or playing sport was a more common response in Trat than in Aranyaprathet. In terms of training or study in the future respondents in Aranyaprathet were more enthusiastic about learning Thai and English languages as well as occupational skills, whereas in Trat they were more interested in general study. Only about a quarter of the sample in both sites said that they participate in regular community events at the temple.

It is difficult to compare attitudes to Thai people as respondents in Aranyaprathet, as commuters, had less contact with Thais. However, findings do suggest that the history of reportedly poor relations between Thai and Cambodians has not changed very much. In Aranyaprathet 70% of respondents had no plans to return to Cambodia, 20% said as soon as they have sufficient money they would return. In Trat 80% thought that they would return but do not know when. Less than a quarter had plans to leave within 12 months.

Thais, tourists, sex and gambling

Border areas are often well known as areas where illicit activities occur and police enforcement sometimes lax. Both sites were areas where gambling took place and both now have legitimate casinos which include hotel and shopping complexes. The 'pull' factors for men increase and in Poipet Thai men cross the border and visit brothels daily, and of course many order women from their hotels and geust houses. In Trat there are reports of brothels not far across the border, behind the casino, where Thai men, and some other nationalities, are the major patrons, mainly men who are visiting from elsewhere.

Uniformed men and other authorities are known to be among the clients of sex workers and some exploit these women, as well as openly or clandestinely facilitating their way across the border. This is indeed a sensitive area but key informants are aware of some of the exploitation that goes on, and it is reported by key informants that some of these men have died of AIDS but the cause of death was not recorded as AIDS. Exploitation not only occurs towards sex workers but also to other migrant workers (see Sophal and Sovannarith 1999).

This is the context in which migrant workers enter, where they often have to avoid police due to their illegal status, where they may have little job security, limited health facilities, where few can speak Thai, and where there knowledge of the transmission and spread of HIV is very limited. They adapt as best they can in their new environs knowing that they are at risk of being arrested, as fishermen and other in occupations they risk their health, they have little security whether their families have accompanied them or not, many have no safety nets. The risk of HIV/AIDS looms high for them but many are not sufficiently informed to know how risky their behaviour might be, or on the other hand, they may be prepared to take risks, as they must do in other areas of their life as migrant workers.

5.2 General Recommendations

Understanding of local conditions and the situation of HIV/AIDS in each site are crucial to forming appropriate recommendations; however, it is also essential to understand the attitudes and perspectives of local agencies - government, NGOs, private sector and all the institutions that make up civil society. Site specific recommendations are made at the end of each chapters 3 and 4 (see sections 3.12 and 4.12). The following are recommendations that in addition to their relevance to the study sites have a wider application. These proposed recommendations may have direct relevant for other cross-border locations, and in turn the development of national level strategies for planning and co-ordination of intervention activities.

1. **Improving legal status:** Illegal status of migrant workers is a major obstacle to the development of health services for the large majority of migrants in Thailand. This not only affects access to health care and the provision of health promotion materials, but it encourages isolation from the Thai population as well as from colleagues in other

industries, thus narrowing the options for developing social networks. These factors limit the potential for developing community and making investments for longer term benefits for themselves and the community as a whole. The Thai government is attempting to develop measures that support registered workers and prohibit others from being in the country. The first step should be to develop a clear policy on registered migrant workers' employment conditions, including provision for health care and social support. Once these policies are legislated, employers should be obliged to follow the regulations closely and any infringements should be dealt with seriously. This will require strict and regular enforcement.

2. **Important factors for developing an 'enabling environment':** Cross-border locations often have their unique administrative and economic power structures. Provincial level authorities are now playing a major role in determining the registration procedures for migrant workers, and perhaps in determining other means of providing legal status. Local immigration and border police will have a role in enforcement and other procedures. In some cases the military may play a role as well. All play a role in the treatment of migrants, legal or not, in the respective areas of their authority. In most instances, these local officials may have 'privileged knowledge' and vested interests in local businesses including commercial sex and drugs. With their tacit support migrant sex workers are brought or trafficked into the vicinity. Some local officials are also known to regularly patronise sex workers. As clearly part of the problem they must be part of the solution. They must participate with the health department, NGOs, private sector and other civil society institutions to create an enabling environment in support of the migrants. This may be perceived as an idealistic strategy; however, a truly enabling environment cannot occur in the absence of such institutions. For effective community responses and sustainability of programming at least a beginning can be attempted through 'pilot' programmes.

3. **Developing monitoring and evaluation tools for border programmes:** Border programmes are usually expensive because of geographical remoteness and the extent of resource mobilisation required. Unlike HIV/AIDS programmes with localised and stable communities within one country, border programmes deal with mobile populations, relatively unstable communities, and ethnic difference. There has been considerable debate as to what are the unique characteristics of border programmes and how these can be translated into monitoring and evaluation indicators for measuring progress in programming. The quantitative and qualitative findings of this study which also draw from other research and program findings are refining our understanding of cross-border locations. Findings and recommendations here point to some useful indicators for targeting migrant workers as well as the broader mobile population groups.

4. **Mass media programmes for border populations**: Many local and migrant people in border areas do not have a clear understanding of the disease and health risks they are facing. There are a range of health issues from accidents and violence to communicable diseases including STDs and HIV that migrants and other population groups are susceptible to. Well coordinated mass media campaigns using television, radio and written materials can be disseminated on both sides of the border in appropriate

languages. The content and means of communication should be well tested in the field. In addition, it may be possible to liaise with national and international media networks to improve the reporting of sensitive issues involving migrant populations (see below).

5. **Advocacy for migrant workers:** With the formation of local and national committees as recommended in the site specific recommendations (3.12 and 4.12) they can authorise a sub-committee to advocate on behalf of workers. A major role for this committee would be to raise awareness on migrant workers in Thailand, conveying an accurate picture of the role of workers in the local and national economy and their rights as workers in Thailand. The committee can liaise with government officials and NGOs, arrange public meetings, as well as communicating with reporters and representatives of the mass media with the objective of influencing a more sensitive approach to reporting on migrant workers. This could be a very constructive contribution to developing a more accepting environment for migrant workers in cross-border locations.

6. **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 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 services to all registered migrant workers. This could be undertaken by raising local funds through health cards or a social security scheme for workers. Funds could support such things as hiring local bilingual interpreters seconded from NGOs or the private sector to work in hospitals or other health facilities.

7. **Training for uniformed officials**: Immigration officials, police and military can be included as mobile groups, they are rotated on a regular basis and are thereby usually living away from home. Findings suggest that many are highly vulnerable to HIV infection, some are implicated in abuses associated with migrant men and women. Training can focus on an appreciation of risk on the border area through providing an informed and comprehensive picture on the situation of HIV/AIDS on the border and the necessity of all mobile groups being informed of safer sex practices. This could be incorporated into programs that deal with legislation on migrant workers and respect for migrant workers rights and the human rights of all migrants.

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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 ______________ Subdistrict __________ 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

Accommodation

27. What is your place of residence?
    ❒ 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
    ❒ nuclear 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
    ___ socializing & 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 ❒ socializing, 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 Seeking 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/Cambodia
State hospital		
Health station		
Private hospital		
Private clinic		
Traditional birth attendance		
at home by mother herself		
Other specify		

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 ____

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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	Myan./ Camb.	Thai	Myan./ Camb.	Thai	Myan./ Camb.	Thai	Myan./ Camb.	Thai	Myan./ Camb.	Thai	Myan./ Camb.	Thai	Myan./ Camb.
1. T.B (infection stage)														
2. Filariasia (infection stage)														
3. Amphetamin/ Heroin addict														
4. Leprosy (infection stage)														
5. Syphillis (3rd stage)														
6. Mental disorder/ Down syndrome														
7. AIDS (full blown)														

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?
❒ no
❒ yes, from what sources? (multiple responses possible)
❒ inter personal source ❒ TV/radio ❒ newspaper/periodicals
❒ poster/sticker ❒ Thai health officers
❒ 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.	tongue.	❒	❒	❒
69.	Chronic diarrhea.	❒	❒	❒
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 everytime 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 practicing 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	❒	❒	❒
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

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?

   ❒ 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. of partners	condom use	
		every time	some time
(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 month

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 co

143. What are condoms useful for (why do you use)?

144. Do condoms affect your feelings and sensations during sex.

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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

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