SOCIO-CULTURAL INFLUENCES on the reproductive health of migrant women

A review of literature in Cambodia, Lao PDR, Thailand and Viet Nam

UNFPA

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Foreword

The right to access reproductive health information and services is a concern regarding migrant women. Barriers to accessing services are frequently institutional, exposing them to greater risk of illness than non-migrant people, and often excluding them from formal medical systems. Less understood are the socio-cultural factors that also play a key role in influencing the behaviour of migrant women, and their access to reproductive health services.

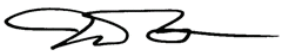
To gain a better understanding of the links between socio-cultural factors and the reproductive health of migrant women in four Mekong sub-region countries – Cambodia, Lao PDR, Thailand and Viet Nam – UNFPA APRO commissioned a series of literature reviews, focusing on migrant women. This report synthesizes the findings from the four reviews and makes recommendations on how policy makers, employers and service providers could better address the reproductive health needs of migrant women.

The focus on socio-cultural factors is essential if we are to understand the multiple factors that impact on migrant women's behavior and preferences for health care. For many women, moving away from their places of origin is disruptive. Lack of familiarity with new locations, less access to traditional support systems, exposure to different lifestyles and influences, and vulnerability to exploitation and abuse are some of the factors that impact on their behavior and health. Without understanding the nexus between these factors and the more commonly documented structural factors that prevent migrants from accessing health care, we have only part of the picture. Behaviour is rooted in gender norms and traditions, cultural practices and beliefs: these need to be understood if the rights of any marginalized population are to be realized.

A key finding from the reviews is that migrant women's reproductive health needs are being neglected – apart that is from interventions addressing STI and HIV prevention which appears to be the main focus of service delivery targeting this group. Their needs include, but are not limited to: pre and post-natal care, maternal health and assisted deliveries for those wishing to have children; contraception, including emergency contraception, to prevent unwanted pregnancies and unsafe abortion; protection and care for those who have experienced violence, particularly sexual violence; and confidential counseling and non-discriminatory reproductive health information and services for all, irrespective of age, marital status, ethnicity and type of employment.

A holistic approach, that addresses the full range of migrant women's needs, and which empowers them to claim their own rights to reproductive health is essential. These elements are at the heart of the Programme of Action of the International Conference on Population and Development (ICPD), and central to the work of UNFPA. If realized, these rights would also contribute to the attainment of the Millennium Development Goals, particularly MDG 5, and also MDGs 3 and 6.

I hope that this report will provide insights and guidance to Government partners in the countries where the studies were conducted, as well as to the staff of UNFPA and other partners that are working to promote the rights of female migrants to enjoy a life of health and equal opportunity.



Nobuko Horibe
UNFPA Regional Director
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Executive Summary

This paper is an overview of the analysis presented in a series of four literature reviews that the United Nations Population Fund (UNFPA) commissioned to identify socio-cultural factors that affect the sexual and reproductive health of female migrants. The reviews encompassed looking at research, study reports and other available documents, mainly from the past decade, on internal migrants in Cambodia, Lao People's Democratic Republic and Viet Nam, and international migrants from Myanmar in Thailand. The reviews were premised on the assumption that socio-cultural factors impact on the potential of female migrants to access sexual and reproductive health information and services and protection from violence. The consultants sought to identify factors enabling access to information and services, as well as examples of good intervention models that might be replicated or scaled up. Potential barriers to access of reproductive health services by female migrants were also described.

In the four countries reviewed, the majority of migrant women were found to be working in factories, the entertainment sector and domestic work. Almost all the literature available focused on the first two sectors, with no studies identified that looked specifically at the situation of domestic workers. Interviews with researchers, relevant staff from government institutions, United Nations agencies and non-governmental organizations, provided supplementary information on research, programmes and interventions addressing the sexual and reproductive health of migrant women.

Migration in South-East Asia

Labour migration grew dramatically in the early 1990s in South-East Asia, with Thailand becoming the main recipient of migrants from other countries in the Mekong region. An estimated 1.8-3 million documented and undocumented migrants from neighbouring countries live in Thailand. Internal migration, however, dominates the flows of people within the region, despite the increasing movements of international migrants. At national level, internal migration rates vary significantly across provinces.

Generally, there are few restrictions on intra-regional migration in the Mekong region and simultaneously there are few initiatives to facilitate safe migration. Poverty and the inability for rural economies to sustain themselves have been identified as the main drivers of labour migration. Political factors are also a trigger in the case of some migrants coming from Myanmar to Thailand.

Migration has grown more feminized in recent decades. In the Mekong region, a large proportion of migrants tend to be young, unmarried women who move without their families.

Migration has lifted many women and their families out of poverty. But the absence of legal and institutional mechanisms to protect their rights shows that economic gains within the region have often not been matched by parallel advances in social protection. Migration for many women means working in precarious and dangerous jobs often characterized by low wages, poor work conditions and lacking employment benefits. Many migrant women lack awareness on how to protect their own rights, including the right to health care.

Review Findings

The literature reviewed showed that many women migrants encountered institutional, legal, economic, social or cultural barriers in accessing public health services. They usually lacked access to reproductive health information and services in their work destinations, a situation which was exacerbated by the fact that low-skilled migrants tended to have low levels of education, with a small proportion having had no education at all.

Several socio-cultural factors were identified as barriers to sexual and reproductive health information and services. For example, where women

did not speak the same language as those in their migration destinations, language barriers were an important factor hindering access to relevant and timely health information and services. Unequal gender relations affected health-seeking behaviour. For example, in the countries reviewed, women were found to hold back on making decisions related to their sexual and reproductive health protection in deference to men. Young women were especially vulnerable to health risks because of their fear of it being found out that they were sexually active before marriage. Health service providers were reported to have prejudicial views of migrant women as not "respectable" and, in many cases, associated with sex work. Among migrants, therefore, there remained a strong preference for seeking traditional practitioners, private services, or over-the-counter medicine, rather than seeking treatment from public health facilities. In all four countries reviewed, significant numbers of unwanted pregnancies and unsafe abortions were reported.

Belief in traditional explanations regarding health also sometimes served as barriers to understanding the seriousness of medical conditions and the necessity to seek immediate treatment. Cultural values such as preservation of "face" were found to have a significant impact on health-seeking behaviour. The fear of being stigmatized as an individual who deviates from societal norms was strong. This finding was closely associated with gender norms ascribed to women, namely that they should remain "good" women, sexually inactive before marriage. In spite of these expectations, in the role of economic provider many women were encouraged to seek employment away from home, often far from the security of traditional norms and support mechanisms. Nonetheless, community, and in particular the role of social networks, was found to be a critical factor influencing women migrants in general, including their sexual and reproductive health behaviour and, possibly, their health care choices.

There were substantial quantitative and qualitative studies conducted on broader migration issues in three of the four countries reviewed – Cambodia, Thailand and Viet Nam – but links between the socio-cultural factors and sexual and reproductive health were rarely the specific focus of studies; such a link remains poorly documented. The literature on the situation of migrant women in Lao PDR is very limited and, given the increase in internal migration, research on a range of issues related to migration would strengthen the existing information available.

Ethnic minority women who until recently were isolated from most development initiatives, are becoming increasingly visible among migrant populations, particularly in Viet Nam and Lao PDR. The nexus between minority cultures, beliefs and practices with migration has barely been explored at all. There is a need for more systematic research on internal migration, especially examining the migration trajectory of internal migrants and the effects on sexual and reproductive health outcomes.

The literature review focused on female migrant workers. However, several of the reports noted the need for corresponding research in relation to male migrants, particularly because male perceptions, knowledge and behaviours are likely to have a significant impact on female migrants' sexual and reproductive health behaviour and outcomes in destination communities. In most contexts, social networks include male migrants, as well as men in destination communities. Socio-cultural factors impacting on male knowledge, attitudes and practice in the realm of sexual and reproductive health, and the links of this with women migrants' health is thus deserving of greater investigation.

The available research and reports of interventions reflected a focus almost entirely on sexually transmitted infections (STIs) and HIV prevention among migrant women, suggesting that priorities have corresponded to national concerns about the spread of HIV and AIDS in the region. The report of the AIDS Commission on Asia in 2008 clearly identified that HIV transmission in Asia was primarily among high-risk groups – sex workers, men who have sex with men and intravenous drug users – some of whom may be migrants. Although the reviewed literature identified that some migrant women engaged in sex work (either directly in commercial establishments or as a side-line to supplement their income), the majority of migrants were employed in low-risk occupations, such as factory work and domestic work. However, the high mobility between employment sectors indicates that, potentially, the sexual and reproductive health of all migrant women may be at risk.

The very narrow clinical focus on STI and HIV prevention, by both governments and non-governmental providers, means that migrant women's other identities – as girlfriends, wives and mothers – has been neglected. Given that a large proportion of migrant women appeared to be young and unmarried, and that societal norms and constraints are no longer necessarily applied or adhered to in migration destinations, potential needs for contraception must be addressed, particularly if unwanted pregnancies and unsafe abortions are

to be avoided. To address the often high levels of unsafe abortion, emergency contraception should be added to the contraceptive mix in each country if not yet available. In Viet Nam and Thailand, significant numbers of the surveyed migrant women were also married and, in addition to contraceptive needs, they were in need of services including ante-natal and post-natal care and access to assisted deliveries and emergency obstetric care. Further research should be conducted to address the broader aspects of reproductive health and associated socio-cultural factors among these women.

Additionally, although a number of the documents reviewed referred to the violence experienced by some migrant women – especially during the migration process and for those engaged in the entertainment and sex industries – there were few projects or programme interventions identified that aimed at protecting them from violence and addressing their right to access related support services.

Several successful interventions to address the sexual and reproductive health needs of migrant women were documented. For example, to address the different language needs among migrant women from Myanmar in Thailand, information and educational materials were developed in the languages of the migrants and, in some locations, systems were established for bi-lingual migrant health workers and volunteers to accompany migrant women to public health services. Health clinics, including mobile clinics and drop-in centres in migrant communities, and clinics providing migrant-friendly services, including referral and counselling, have been successfully established in Thailand for migrants from Myanmar. In all four countries reviewed, peer educators were recruited and trained to work with migrant women, usually in their places of employment, and most often in work related to the entertainment industry where women frequently engaged in commercial or transactional sex. This approach was widely regarded as successful, although often challenging due to the high mobility of migrants.

Recommendations

Given the general lack of regulatory systems in place to protect migrant workers, and insurance schemes to ensure their access to health services, a number of recommendations emerged from the reviews. A key identified need was for increased advocacy among policy-makers to ensure that migrant rights are included in all relevant national policies, and that service provision addresses their broad reproductive health needs.

Recommendations were made that employers of migrant women, particularly factory owners and those involved in entertainment sector establishments, should promote reproductive health information through the workplace, using peer education strategies. Factory owners should make services available on site, or create time when staff can access external services during work hours without docking their pay.

Health service providers would benefit from being trained in client-friendly service provision to ensure that migrant women are not discriminated against, particularly unmarried women, those engaging in sex work, and those from ethnic minority communities. This would entail strengthening the capacity of health providers to better understand socio-cultural influences on sexual and reproductive health, and the way gender norms affect health-seeking behaviour and the choices of female migrants. Increased attention should be paid to promoting behaviour-change communication strategies, and information and education materials that respond directly to female migrants' health vulnerabilities, and that are presented in a language and format that suits their levels of education, existing knowledge and preferences. A shift from a purely biomedical approach focusing on STI and HIV prevention towards a holistic approach that addresses the full range of migrant women's reproductive and other health needs, in non-discriminatory settings, would likely encourage more women to use available services.

In addition, women migrants themselves need to be supported and empowered to advocate for and claim their own rights to health care and health protection. Migrant associations and NGOs could facilitate migrant women to set up support networks and groups to discuss issues related to migration, including sexual and reproductive health, and violence. The Thailand and Viet Nam reviews provide examples of such initiatives.

Work could also be done with worker's and employer's organisations, and with law enforcement officers to facilitate women migrants' access to justice and to ensure that rights violations are addressed. In all four countries this would entail considerable capacity strengthening, given the vested interests that some law enforcement officers are reported to have in colluding with negligent employers and other intermediaries involved in the migration process. Lastly, in some contexts, and because of their influence at the community level, mass organisations and religious leaders' capacity could be strengthened to support migrant women's rights.

Acronyms

ASEAN	Association of Southeast Asian Nations
HIV	Human Immunodeficiency Virus
Lao PDR	Lao People's Democratic Republic
NGO	Non-Governmental Organization
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand programme
RACHA	Reproductive and Child Health Alliance
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

CHAPTER ONE

Introduction

This paper is an overview of the analysis presented in a series of four literature reviews that the United Nations Population Fund (UNFPA) commissioned to identify socio-cultural factors that affect the sexual and reproductive health of female migrants. The reviews encompassed looking at research and study reports and other available documents, mainly from the past decade, regarding internal migrants in Cambodia, Lao PDR and Viet Nam, and international migrants from Myanmar in Thailand.[1] The reviews were premised on the assumption that socio-cultural factors impact on the potential of female migrants to access sexual and reproductive health information and services and protection from violence. The research sought to identify enabling factors and barriers to information and services, and examples of good intervention models, as a way to improve reproductive health service provision to female migrants.

1.1 Migration in South-East Asia

Movements of workers across and within national borders have increased around the world in recent decades. South-East Asia is no exception, with four major cross-border flows in the Mekong region: from Yunnan to the three countries that share its borders; from Myanmar to Thailand; from Viet Nam to Lao PDR and Cambodia; and from Cambodia and Lao PDR to Thailand. That Lao PDR, Viet Nam and Yunnan province are transitioning from centrally planned economies towards more market economies has spurred their internal migration.[2] Similarly, increased rural to urban migration since the late 1990s in Cambodia reflects the opening up of the country to a free market economy and subsequent high economic growth.[3]

Within Asia, labour migration grew dramatically in the early 1990s, with Thailand quickly becoming a magnet for

migrants from the other countries in the Mekong region. Thailand now has an estimated 1.8–3 million documented and undocumented migrants.[4] The legal channels of migration[5] into Thailand have been problematic, leading to large-scale undocumented migration and, as such, make the tracking of actual numbers difficult.[6]

The bulk of the migration flows into and from this region tend to be voluntary and economic-oriented, that is, the selling of labour in exchange for wages. For example, professional and high-skilled migrants enter Thailand on work visas, while low-skilled workers are granted work permits. There are also large numbers of people[7] entering the country on day passes, which makes their entry legal, although many end up overstaying, thus becoming undocumented workers. Together with a booming economy (at close to 8 per cent growth in 2010),[8] the demographic characteristics of Thailand make it open to receiving foreign labour: a low total population growth rate, a low fertility rate, lowest growth rate of its 15–39 age cohort, which forms the majority of the working-age group, and an ageing population. In contrast to Thailand, countries such as Lao PDR and Cambodia have higher population growth rates and a greater proportion of people in the working-age group. Increasingly, Cambodia is also becoming a recipient of cross-border migrants.

In spite of the large migration flows across national borders, internal migration still dominates in South-East Asia. The general trend has been rural-to-rural migration, driven largely by development, although rural-to-urban migration has accelerated in recent decades. From 1994 to 1999, 37 per cent of the internal Vietnamese migrants were rural-rural migrants, while 27 per cent were rural-to-urban migrants.[9] In Lao PDR, where internal migration was found to be more of a trend in the North compared with the South, the urban population increased from 17 to 27 per cent over the 1995–2005 period. In Cambodia, data from the 2004 census indicated that 31.5% of the population was involved in migration, with rural to rural migration being highest at 67 per cent, and 13.9 per cent rural to urban.[10] In Thailand, rural-to-urban migration has been more significant than rural-to-rural migration.[11]

Migration rates vary significantly within countries and across provinces. In Ho Chi Minh City, Ha Noi and Binh Duong province in Viet Nam, migrant populations were reported as contributing to more than 10 per cent of the total population. By contrast, in other provinces, migrant populations accounted for less than 1 per cent of the total population.

1.2 Migration policies and legal and regulatory frameworks

By and large, there are few restrictions on intra-regional migration in the Mekong region and, at the same time, few initiatives to facilitate safe migration. Due to uneven patterns of development and highly varied demographic trends across the countries, migration is expected to continue in the decades to come.[12] To ensure protection for migrant workers means the establishment and implementation of regulatory frameworks, such as that of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers.[13] Within countries, migration policies and legal frameworks tend to be highly varied.

In Cambodia, the Government does not have a specific policy on rural-to-urban migration, although the Rectangular Strategy for Growth, Employment, Equity and Efficiency, currently in its second phase, implicitly encourages migration. This strategy aims to improve the living standards of residents living in rural areas by seeking to channel more investment into non-agriculture-based activities, thereby generating off-farm income through the establishment of small and medium enterprises. The strategy recognizes that landless and near-landless rural women and men turn to migration in search of non-agriculture-based employment because of limited options to improve their living standards.

Over the past 30 years, the Government of Lao PDR has instituted policies related to agriculture and resettlement to either keep people in place or to move them to particular places. The policy restricting land use for swidden agriculture or shifting cultivation[14] accelerated outmigration because of food insecurity. Economic development led the Government to promote resettlement schemes within rural areas partially as a way to address inequalities. These movements tend to be managed by village heads or authorities, unlike cross-border migration, which is government regularized and controlled. For example, Lao PDR and Thailand developed a bilateral agreement to regulate labour migration to Thailand in 2002.[15] More recent economic development has seen the establishment of 'economic corridors', through the construction of roads linking Lao PDR with neighbouring countries, large scale mining and dam construction projects, as well as the growth of light industry, all of which have increased rural people's movement to locations with opportunities for employment.

In Thailand, the Government has been preoccupied with managing migrant streams from neighbouring Cambodia, Lao PDR and Myanmar – major source countries for its low-skilled workers – since the early 1990s. Periodically it has mandated that Thai employers register undocumented migrant employees, with the aim of regularizing those workers. But this has disadvantaged migrants because the cost of undertaking registration is often transferred to them by employers.[16] More recently, there was a nationality verification exercise in which 1 million migrants registered from 2009 to March 2010.[17] While nationals from Cambodia and Lao PDR did not face difficulties, those from Myanmar were at risk of losing their jobs because the Myanmar Government required its citizens to return home to process the required paperwork.

In Viet Nam, reforms in the household registration system appear to have had a relaxing effect on the restriction of rural-to-urban migration. Before the household registration system came into effect, the *ho khau* system was used to control and monitor changes in people's residence. The residential status of people is important for determining their access to government services, such as health care.[18] Only residents registered in the place they reside have full entitlement to government services, while those who are residents of other areas have to pay for those services, resulting in social exclusion within this group. Due to the ineffective and inconsistent application of these reforms, migrants still find it difficult to access basic services.

Current labour laws in Viet Nam do not recognize women migrants as a vulnerable group. Consequently, there is no legislative framework to protect them. Significant proportions of urban migrants are either self-employed or work in short-term or casual employment and have no formal labour contracts. Domestic workers, for example, are not protected by the law.[19] While the Ministry of Labour is preparing a decree to regulate the domestic work sector, the feasibility of this new law as well as the State's capacity to enforce the proposed legislation have been called into question.[20]

1.3 Socio-economic determinants of migration

Countries of the Mekong region have been described as having a "stand-by army" of millions of workers ready to take on employment anywhere.[21] Many factors drive both internal and international migration in South-East Asia. Chief among them are poverty and the inability for rural economies to sustain themselves. Rural-to-urban migration has been dominated by poorer migrants moving from the less-developed areas to more urbanized areas in response to increased industrialization. In the Mekong region, popular migrant destinations include Bangkok, Ho Chi Minh City, Ha Noi, Phnom Penh and Vientiane.

While the economic impulse to migrate forms the primary factor for seeking employment away from home, there are also personal reasons. Family duty may require elder children to leave home for work, or marital problems may push women to find work elsewhere.[22] Women have found work abroad to fulfil their own desires. Migration also is an avenue for younger rural-to-urban migrants, if only on a temporary or seasonal basis, who are looking for socio-cultural experiences more typical of urban than rural contexts.[23] The political economy of rural-to-urban migration, however, is a stronger driver of migration in most instances rather than the socio-cultural dimensions of urban living.

In addition to economic reasons for migrating, political factors should also be emphasized in the case of those moving from Myanmar to Thailand. In this situation, some migration has been fuelled by internal conflict, which has also limited development of economic opportunities in Myanmar, especially in border areas largely populated by ethnic minorities.

1.4 Feminization of migration

Striking in these times is the increasing feminization of migration. Current estimates point out that two-thirds of migrants in South-East Asia constitute women, reflecting the rising demand for the kinds of work that typically engage women. In the Mekong region, data estimates reflect a slightly larger proportion of men migrating than women.[24] According to the latest data from the Thailand Office of Foreign Workers Administration, male migrants from Cambodia, Lao PDR and Myanmar totalled 54 per cent of all registered migrants. Because many women migrants engage in domestic or sex work – sectors with poor official figures because of underreporting or due to lack of registration – there may be a greater proportion of women migrants in Thailand than assumed.[25] Internal migration in the region has also consisted of increases in the numbers of women migrants.

2009 census data in Viet Nam[26] showed that women accounted for more than half of the migrant population. This is attributed to the decline of the agriculture sector and the rise of job opportunities for women in urban areas and industrial zones.[27] Analysis from the 2005 Census in Lao PDR shows that, among migrants, the percentage of never married males and never married females was 51.7 and 47.2 respectively, indicating that slightly more males than females migrated at that time.[28] A 2003 study in Cambodia, referencing data from the National Institute of Statistics, reported that 35 per cent of the Cambodian population were migrants – an increase of four points over the 1998 Census (31 per cent). The proportion of migrating males was reported to be 35 per cent, and migrating females 34 per cent, with larger actual numbers of female migrants due to the higher number of women in the population.[29]

Migrant women have tended to be young. The push to migrate typically comes from the families of women migrants. In fact, there are reports of a disproportionately large number of daughters migrating compared with sons. Usually the older daughters migrate, taking on the role of "dutiful daughter". They are obliged to forsake their schooling and move to the city to find work to help the family,[30] leaving the youngest to stay behind to eventually care for ageing parents. A 2010 study on the status of factory workers in Lao PDR revealed that the "need to leave" for women migrants was not only for income, employment and remittance purposes but also as part of growing up and assuming the task of providing for others.[31] There is also evidence to show that some daughters resort to selling sex to procure money for their families.

Perceptions around women's roles have shifted as a result of female migration, in terms of both the way in which women migrants are perceived, and how they perceive themselves. Women who leave their communities and send remittances home also enjoy a relatively independent lifestyle. For some women migrants, rural-to-urban migration is bound up with the identity of being a "modern" woman and the desire for a modern lifestyle.[32] Research in northern Lao PDR also suggests that some migrating ethnic minority women are using their own agency to move beyond traditional roles held by women in their original highland communities by engaging in sex work. In the case of one ethnic group, it is suggested that this has enabled them to improve their status and economic standing, whilst the same time supporting their families.[33, 34]

Migration for work among these women is, however, a two-edged sword. While it has lifted many migrant women as well as their families out of poverty, the abuses these women experience in the migration process are numerous due to the absence of legal and institutional mechanisms to protect their rights. In addition, many migrant women lack awareness on how to protect their rights in the migration process.

While female migrants may receive better incomes in the places of destination than if they had stayed in their home towns and villages, living in the city may place them at risk of harmful situations. Ties with kin and those left behind, which would have normally formed the basic social support networks of these women, are absent when they navigate living in the city. Compared with male migrants, these same ties have served to disadvantage some female migrants who returned home to rural areas.[35]

Female migrants experience other vulnerabilities. Migration means working in precarious and dangerous jobs for many of them. In Cambodia, according to a 2009 report, there were an estimated 4,000 beer-promotion workers – most aged between 20 and 29 years old – employed in beer gardens, karaoke bars, nightclubs and soup shops. Beer promotion is associated with sex work, and many of the beer promoters do sell sex (though not necessarily identifying as sex workers). These women are regularly subjected to verbal abuse and sexual harassment. Because they work on a commission basis, many end up selling beer at all costs, even if it means having to engage in sex work.[36]

1.5 Significance and scope of the review

The human rights of migrants have long been a concern,[37] in particular their rights to health. Being poorly skilled reduces both international and internal migrants to a marginal status and thus the various vulnerabilities that come with that. Many encounter barriers in accessing the national health care system, and they often lack reproductive health information and services in their work destinations. These barriers may be institutional, legal, economic, social or cultural. As migrants move away from their places of origin, traditional support networks are lost and, in the absence of traditional norms and expectations, many end up taking risks with their health. Factoring in other characteristics, such as age, socio-economic status, financial constraints, ethnicity and cultural and language differences, migrants generally live within a context that is different to that of local populations, thereby reinforcing their marginality.

This paper is a summary of reviews of identified literature regarding female migrants, and literature relating to the sexual and reproductive health of migrant women – as far as it exists – from the four selected Mekong countries. As noted, the reviews focused on internal female migrants in Cambodia, Lao PDR and Viet Nam, and at cross-border migrants from Myanmar in Thailand. In terms of geographic scope, the Thailand review covered dominant destination areas. The other country reviews examined the internal migration populations more generally.

The reviews were commissioned on the basis of an assumption that socio-cultural factors have the potential to enable or curtail access to sexual and reproductive health information and services among these women, many of whom experience greater vulnerability due to their status as migrants. Acknowledging the significance of socio-cultural factors on the sexual and reproductive health choices and outcomes for migrants is to recognize that sexual and reproductive health cannot be seen from a purely biomedical perspective. In other words, the health of migrants is also affected by socio-cultural factors and how migrants relate to their environment. For example, health and health-seeking behaviours are influenced by factors linked to the individual, such as membership and identity within a group, as well as how the individual relates to those outside the group, including social contacts and health service providers.

In this review, the socio-cultural and economic standing of migrants as members of distinct groups with specific qualities and unique backgrounds

are viewed as critical factors in the choices they make. An understanding of the environment is critical because socio-cultural factors related to the migration narratives of each individual migrant serve to enable or hinder the maintenance of good health. The availability, or otherwise, of reproductive health services in places of origin – and whether or not these have previously been accessed by women that migrate – is likely another influencing factor. However no material reviewed addressed this aspect.

The review focuses on female migrants, who are especially vulnerable to health risks because they are more likely to be exploited or abused sexually, or may resort to risky sexual behaviour for economic survival. The vulnerability of some women is also heightened because, as migrants, they tend to be engaged in jobs in which work conditions may compromise their health status. Some engage in unprotected sex, either through work or socially, which puts them at risk of STIs and HIV infection. Because of the lack of knowledge and lack of access to health information and services, particularly regarding contraception, female migrants may also be vulnerable to unwanted pregnancy and unsafe abortion. Lack of access to ante-natal and post-natal health services in destination areas may subject a female migrant and her infant to health risks. Additionally, female migrants are also often exposed to violence during transit to, or at the work destination.

This review is significant for a number of reasons. First, the analysis serves to increase understanding of the specific links between sexual and reproductive health and migration processes. Because the sexual and reproductive health of women migrants is an under-researched topic, and there is a lack of substantive information on related matters in the Mekong region, the review is a useful lens into the specific sexual and reproductive health needs of female migrants. The review describes how socio-cultural factors influence sexual behaviour, as well as decisions regarding whether or not to use reproductive health services. It also goes some way towards filling a gap in understanding the extent to which socio-cultural norms and practices impact on female migrants' health behaviour and outcomes.

Second, the analysis draws attention to the significant lack of documentation and insight on how the migration process exposes female migrants to various forms of health risks and how they are unable to access relevant health services in such circumstances. The findings and conclusions of the review thus can be used to inform health policy targeted at migrants, with the aim of improving the quality and reach of health services for this group.

CHAPTER TWO

Methodology

The literature review primarily reflects secondary sources, mostly published materials, detailing as much as possible the sexual and reproductive health situation of female migrants in the four selected Mekong region countries (Cambodia, Lao PDR, Thailand and Viet Nam). Most materials reviewed were in English, although in Cambodia, Viet Nam and Thailand there were also some relevant materials in the vernacular. Much of the literature consulted was based on qualitative research data derived from focus group discussions with women migrants.

Data was also gathered from face-to-face interviews with government officials, health professionals, and staff of United Nations agencies, international organizations (IOs) and non-governmental organizations (NGOs). Interviews were also conducted with independent researchers. In some cases, face-to-face interviews took place by telephone or e-mail exchange. The four reviews were designed to be literature reviews, and the follow-up interviews served to corroborate the findings in the reviewed materials.

Due to time and resource constraints, none of the country reviews involved researching primary data from interviews with female migrants, with the exception of one review (Cambodia) in which the consultant reported having a number of informal discussions with garment workers on a range of subjects, including sexual and reproductive health.

2.1 Summary of the literature

The literature on links between sexual and reproductive health and socio-cultural factors in relation to female migrants was fairly rich in Cambodia, Thailand and Viet Nam, but there was only limited material available in Lao PDR. The Lao PDR country review thus examined sources on migration in

general, and on reproductive health and ethnicity, in an effort to triangulate findings as best as possible.

As noted, most of the sources used for the country reviews were qualitative rather than quantitative. The academic literature available was mainly qualitative and included anthropological analyses. The IO and NGO literature included quantitative analyses. Government reports also were reviewed.

The reviewed literature covered the following subtopics: i) demographic characteristics of women migrants, ii) employment factors, iii) workplace practices, iv) socio-cultural characteristics, v) vulnerabilities of women migrants, including sexual and reproductive health behaviours, outcomes and risks (addressing maternal health, family planning, unsafe abortion, reproductive tract infections, STIs and HIV, vi) gender norms and relations, vii) knowledge, attitudes and practices related to sexual and reproductive health among female migrants, viii) health-seeking behaviours, including traditional medical practices, ix) health insurance coverage, x) the role of social networks and migrant communities on sexual and reproductive health choices, xi) gender-based violence and xii) health service provision.

The various findings showed that in general the bulk of the literature has focused on health risks and behaviours in relation to STIs and HIV. There were far fewer documented studies addressing the broader aspects of reproductive health, such as maternal health, contraception, unwanted pregnancy and gender-based violence. Additionally, no literature was found that specifically focused on socio-cultural links with sexual and reproductive health among migrant women, although a number of documents indirectly commented on these factors.

Language caveat

Female migrants from Myanmar are not a homogeneous group because they come from a variety of ethnic groups. Because women from different ethnic groups are not clearly distinguished in Thailand, the review for Thailand uses the term "Burmese migrant women" along with "female migrants from Myanmar" because both terms are generally used. Where the specific ethnicity of Burmese migrant women was mentioned, such details are included.

CHAPTER THREE

Overview of Findings

3.1 Profile of the migrant populations

Age and marital status

The majority of migrants cited in the reviewed reports in the four countries tended to be young, unmarried females. Migration among the young tends to be temporary and for short periods. As such, migrant women generally move without their families. The desire to seek better economic opportunities for themselves and their families was the main reason given for migrating. Marital status impacts on mobility and thus being unmarried presents an advantage.

In Viet Nam, internal migrants, especially female migrants, have been relatively young and predominantly single. The median age of inter-provincial, inter-district and intra-district migrants in 2009 was 24, 25, and 26 years, respectively. These individuals usually migrated of their own volition,

unlike family migration, which tended to occur in response to government-directed migration schemes.

Similarly, many female migrant workers from Myanmar in Thailand were young and in their reproductive age, with the largest group falling in the age cohort of 20–39 years.[38] Data from the different studies indicated that the majority of female migrants from Myanmar were married and living with their spouse. The marital status of the women varied however, depending on the types of employment and reflecting employer demand for single or married women because of the nature of the job. Another variable might perhaps be whether or not the migrants were registered (legal) or unregistered, with more legal migrants being accompanied by their spouse. Unmarried women migrants dominated the findings on sex work and domestic and factory work, while construction work consisted of larger numbers of married women.[39]

In Lao PDR, women who migrated within the country were usually young, between 15 and 25 years, and around three-quarters of them left home when still unmarried.[40] In fact, young people (18-35) constituted 74 per cent of migrants.[41] Analysis from the 1995 and 2005 censuses shows that, among both males and females, those who had never married were more likely to migrate. The proportion of the younger population among migrant females was more than among their resident counterparts: of migrant females aged 15-24 and 25-49, the percentages were 46 and 33.5, compared to the corresponding proportions of 27 and 39 for resident females in the corresponding age groups.[42]

In Cambodia, a study focusing on youth migration with a sample size of 250 migrant women aged 15-24 years, found that the majority were in the age cohort of 18-21 years.[43]

In the Thailand context, it is interesting to note that the marital status of women migrants from Myanmar changed over time, indicating that the longer they stayed in a destination area the more likely they were to marry, possibly seeking protection through marriage as one report[44] suggested, although they were also of a typical marrying age.

Education

The educational profile of women migrants is critical to their reproductive well-being because a higher level of education is considered an important

factor in improved reproductive health knowledge and related behaviour. Thus, the more educated a migrant woman is, the more likely she can protect herself against health risks. Generally, low-skilled migrants tend to have low levels of education, while a small proportion may not have any education at all.

Most young women from Lao PDR who migrated had some education and, in some cases, at least a secondary school education[45] and, according to some of the reviewed literature, they did not represent the poorest segments of a community.[46] However, low levels of education as well as marginal status have pushed some women into certain types of work. In the North of Lao PDR, a study conducted in 2000 found that sex workers had higher-than-average education.[47] It could therefore be surmised that these women might also have had some access to information on sexual and reproductive health (through sexuality education in school, for example). Given the very low coverage and rather poor quality of sexuality education in Lao PDR to date, this seems unlikely however.[48] The profile of migrant women in northern Lao PDR appears to be changing however, with increasing 'recruitment' of poor, uneducated, ethnic minority women to work in beer bars.[49]

Thailand's migrants demonstrated a different trend. The educational levels of the female migrant workers from Myanmar varied among those living and working in different areas of Thailand, with trends changing over time. While the majority of Burmese migrant women were found to have less than five years of education, the number of those with no schooling was much higher, particularly in Chiang Mai, in contrast to those in Ranong province.[50] Among the migrant women in the coastal provinces, there were greater numbers of women with more years of schooling over time.[51] The change in the level of education among them might reflect the fact that new migrants have slightly more education. This could possibly be linked to increasingly limited economic opportunities in different parts of Myanmar, driving more educated women to seek employment prospects across the border in Thailand.

Ethnicity

The Mekong region is marked by ethnic diversity. Migratory patterns across and within the countries in the region indicate that among some ethnic groups there is evidence of migration, increasingly involving women. Owing to barriers in language, low education levels, differences in socio-economic status and in cultural and social norms, minority female migrants are

among the most vulnerable. In fact, ethnicity could be taken as a proxy for characteristics such as socio-economic status[52] on the one hand, and cultural attitudes, beliefs and practices[53] on the other.

The Kinh constitutes the majority population in Viet Nam, but there are numerous minority groups. The most updated data is the 2009 census, which showed that the proportion of inter-provincial ethnic minority female migrants was about 2 per cent of the total population of minority groups.[17]

Migrant women from Myanmar in Thailand come from different ethnic backgrounds, reflecting the ethnic landscape in their home country. The literature reviewed suggested that the largest group represented were the Burman, majority population; studies also referred to significant numbers of migrants from Shan, Mon and Karen ethnic groups. These different ethnic groups tended to cluster in certain areas: for example, the Burman congregated in Chiang Mai and Tak provinces and in coastal areas, while the Mon clustered in the coastal provinces, and the Karen are predominantly in the northern provinces of Thailand close to the Myanmar border.[54]

Certain ethnic groups from Myanmar tended to dominate specific occupational groups.[55] For example, the fishing and related sectors employed mostly Mon and, to a lesser extent, Burman; the manufacturing sector employed Burman, Mon and Karen groups; in contrast, the agriculture sector has been dominated by the Karen; and the domestic work sector has absorbed mostly Burman and Shan women.

In Lao PDR, there has been long-standing migration associated with the government's resettlement policies that encouraged highland ethnic people to move to the lowlands. Increasingly women from some of these minorities are further migrating within their local areas, seeking opportunities to improve their economic status.[56,57] Migration flows to the urban areas have also included certain ethnic groups because of rapid development and social change in communities of origin, particularly those affected by large infrastructure projects, and by the opening up of parts of the country through construction of 'economic corridors'. The ethnic groups most dominant in migration included the Thai Deng, a lowland group with a large social network facilitating movement, and the Khmu, a highland people.

Although women migrants from minority ethnic backgrounds generally face greater vulnerability compared with their counterparts from dominant ethnic groups, this pattern was not identified in the literature reviewed in Cambodia. This is possibly because the ethnic minority communities are much smaller population-wise than in the other countries where the reviews were conducted and therefore, if they exist, ethnic migrants might be less visible in relation to the larger migrant population.

Gender norms and identity

In comparison with women in many other Asian countries, those in South-East Asia, with the exception of Viet Nam, have enjoyed a relatively high status: they retain their individual names, kinship patterns are mostly bilateral or matrilineal, and they can also claim equal property rights. Women are also relatively equal to men in the economic sphere and even play a leading role in many economic activities.[58]

Women nevertheless experience gender inequalities in many aspects of their lives. Religion, for instance, has accorded higher status to men, thereby undermining the overall position and status otherwise held by women.

Theravada Buddhism, the dominant religion of the people in three Mekong countries included in the review, accords a higher spiritual position to men as well as demarcating male and female ritual spaces, thereby reinforcing male hegemony and women's inferiority.[59] In spite of the apparent negative consequences certain Buddhist teachings and practices have had on women's role in the religious realm, there have been arguments put forth that women have been important supporters of Theravada Buddhism through which the concepts of motherhood and merit-making have enabled them to express their piety and to develop links with the monkhood.[60]

The widespread acceptance of patriarchal beliefs and practices associated with the influence of Confucianism impact on the status of women in several Mekong region countries, including Cambodia and Lao PDR.

In Viet Nam, in particular, Confucianism has relegated women to a subordinate position to men, largely because of its patriarchal characteristics. Unequal gender ideologies persist even though the country's constitution and laws promote gender equality in every arena – political, economic, cultural and social. However, the patrilineal and patrilocal family system, coupled with a strong son preference, disadvantages women in everyday life. For example, although Vietnamese civil laws of inheritance enable sons and daughters to have equal rights to inheritance, the customary inheritance law practised in rural areas favours sons over daughters. According to a 2009 report, only 3 per cent of Land Use Certificates were registered in both the names of a couple, although both should be registered on the certificate according to the 2004 Land Law.[61]

Additionally, traditional Vietnamese values posit that women are responsible for the household, childcare and the happiness of the family, even at the expense of sacrificing personal goals. Women are expected to be "good wives", demonstrating kindness, tidiness, domestic skills and obedience at all times. Confucian values support a strictly hierarchical order within the family. Women are obliged to adhere to the "three obediences": to the father (before marriage), to the husband (after marriage) and to the oldest son (should the husband pass away). Domestic violence as well as sex initiated by a husband against the consent of a woman is culturally accepted as a woman's expression of her obedience to her husband.

There have been assertions about religious ideologies being a cultural source of discrimination against women at the everyday level, curtailing the

prestige and status they otherwise have enjoyed to some extent. As a result, male dominance has been demonstrated in different arenas and women's expression of their sexuality has been suppressed. Literature reviewed suggested that, in Myanmar culture, men are reported to have some 'control' over women's bodies and their sexuality. There are still cultural taboos against unmarried women discussing sex and sexuality, despite changing social norms that include reported increased sexual activity, especially among unmarried women, as reported among migrants in Thailand.[62] As such, women's autonomy has been compromised – women are not seen as equals to men.

In Cambodia, expectations about the role of women are reflected in *chbab srey* – a prescriptive code setting out a woman's obligation to her husband and a daughter's obligation to her father – which perpetuate the dominance of culturally ascribed gender roles. This reference also reflects other notions of gender inequality incorporated in religious discourse associated with Buddhism or popular expressions, such as "men are like gold while women are like silver" or "the ripening fruit should not be picked before it is fully ripened".[63] According to the author of the Cambodia report, these references are consistent with the representation of young, poorly educated rural women as relatively powerless and subject to influences they have no control over.

Sexual norms are also male biased in Cambodia. Double standards regarding attitudes towards male and female pre-marital sexual behaviour were

GOOD PRACTICE

Cambodia Health Education Media Services (CHEMS)

Dissemination of sexual and reproductive health information does not need to be restricted to printed materials. Cambodia has been broadcasting phone-in and talk-back radio shows on various sexual and reproductive health topics targeting young people. Over time people from all different backgrounds were drawn to the programme because of its popularity. CHEMS also produced television soap operas highlighting the tensions between tradition and modernity and changing societal values, especially around sexuality.

http://www.chems.org.kh

reported in a 2009 study. More than 25 per cent of males stated that it was acceptable for boys to engage in premarital sex, and only slightly more than 6 per cent considered it acceptable for girls. On the same topic, while less than 7 per cent of girls considered it acceptable for boys to have sex before marriage, less than 4 per cent thought the same for girls.[64] The findings are critical because they demonstrate that while not every young female is opposed to premarital sex, at the same time, not every young male is supportive of premarital sex. That the topic of sex is openly discussed is also culturally constructed and differs across the sexes, with agreement by both sexes that such discussions are more acceptable among boys than girls.

Gender norms also frame women's sexuality in a way that leaves them powerless. There is a strong notion that women do not have full ownership of their sexuality but rather that it belongs to society. In Lao PDR, traditional gender norms, by way of dominant cultural constructs spelling out how men and women are to behave in society, tend to be strong, reinforcing women's subordination to men. Traditional gender norms are especially obvious in poor, rural households and among ethnic minorities. Previously, women's mobility was restricted, but this has been changing over the years. Now that migrant daughters' remittances constitute a significant contribution to the household economy, a new social position has been created for the daughter, including among ethnic minority women.[65] Because households do not have total control over the daughters' earnings, this has boosted women's autonomy through financial independence.[66]

Employment sectors

Most women migrants in the reviewed literature were employed in temporary, low-end or "3D" jobs – dangerous, difficult and dirty – or traditionally "female" occupations, characterized by low wages, poor work conditions and lacking employment benefits.[67] In Cambodia, for example, women migrants were described as working as hairdressers, petrol and cigarette sellers, manicurists, shop assistants and fruit vendors.[68] Women migrants also dominated the domestic work sector,[69] with a smaller proportion employed in sex work, the entertainment industry, the garment industry, fisheries and the agriculture sector.[70] In Lao PDR, women migrants were found in the garment industry and entertainment venues such as beer bars, karaoke bars and discos, and in the domestic work sector. In Viet Nam, literature described women working in industrial zones in the garment and footwear industries, and in the service

GOOD PRACTICE **Lao beer company support for beer promoters**

So as to protect female beer promoters from potential harassment from male clients, a beer company in Lao PDR does not allow female staff to sit, drink or eat with clients. Unlike their peers working for other beer companies, or for private bar owners, they wear comfortable uniforms and are not expected to wear short skirts and high heels. Transport is also provided to and from work for staff to protect them from sexual harassment or violence. Female beer promoters appreciated these measures and saw themselves as being better off than their peers in these respects.

Webber, G. and Spitzer, D. (2010). "Sexual and reproductive health issues facing Southeast Asian beer promoters: a qualitative pilot study", BMC Public Health 2010, http://www.biomedcentral.com/1471-2458/10/389

sector as domestic workers or waitresses. One study reviewed described in some depth work undertaken by migrant women as beer promoters in all four of the countries.[71]

The kind of work migrant women take on is important to their health-seeking behaviour because the job either enables or inhibits them from seeking health information and services, and may even increase their health risks. For example, in Thailand rates of abortion were found to be particularly high among factory workers because employers did not permit them to work while pregnant.[72]

Those in the domestic work sector have no legal employment contracts, which opens the potential to labour abuses and therefore health risks. Sex work across the four countries presents obvious sexual and reproductive health risks, which become accentuated when other factors related to health-seeking behaviour are taken into account.

3.2 Relationship with "host" community: Structural, policy and social factors impacting on reproductive health care access and utilisation

Structural factors, including economic resources, policy support, functions associated with governments such as educational and healthcare systems,

and societal attitudes all play a part in influencing health-seeking behaviour.[73] Authors of three of the reviews posited that the availability of sexuality education during school years, and of health services in places of origin, might have had a protective function for women migrants – had they been widely available.

Other factors influencing health seeking behaviour include the nature of work undertaken, the legal and social status of migrant women, financial considerations, health insurance coverage, physical access to reproductive health services in destination locations, as well as convenience of opening hours and availability of privacy and confidentiality, relationship with authorities, marital status, and attitudes of health service providers.

Sexual and reproductive health education

Sexuality education and life skills are critical to empowering migrants. There have been reported obstacles to introducing sexuality education into schools in the Mekong countries however, thus limiting the possibility that migrant women might have accessed such information prior to migrating. The lack of political will to integrate sexuality education in the school system in some instances is one such obstacle, due to the oft-stated "cultural sensitivities"

towards addressing related issues. Where there have been attempts to introduce sexuality education in the formal education systems, the information has been padded with moral underpinnings. Additionally, teachers have been ill equipped to teach related issues. There have also been attempts to provide sexuality and life skills education through health education outreach efforts of international organizations and NGOs, but these have been largely piecemeal and unsustainable over long periods.

In Viet Nam, for example, sex education was introduced into the teaching curriculum of the subject "population education" in the 1980s, covering sexuality, reproductive anatomy and physiology, while the social aspects of sexuality as well as ethical and legal responsibilities of every citizen were incorporated into "citizen education". Confucian morality, which treats sexuality as a "taboo" topic, makes it problematic for school-based sexuality education to equip students with the necessary knowledge and skills to engage in safe sex behaviours. In addition, teacher training capacity on sexuality education has been inadequate and teachers have often failed to convey appropriate messages. This means that migrant women today who have received some education are unlikely to have had access to comprehensive reproductive health information when at school.

There have been recent attempts by UNFPA and the United Nations Education, Science and Cultural Organization to renew the school curriculum on sexuality education by providing technical assistance to Viet Nam's Ministry of Education and Training (in 2005), aimed at increasing the capacity of school teachers as well as developing a new curriculum. For children who have never attended or who have dropped out of the formal school system, there is no other government programme. In some provinces, international organizations or NGOs have offered some reproductive health education for street children. These efforts, however, were extended to specific communities and did not target communities dominated by migrants. Moreover, because the implementation of sexuality education has been uneven across the country, knowledge of sexual and reproductive health among migrants is generally limited. Results from the 2004 Viet Nam Migration Survey indicated that the majority of women migrants did not know the causes of STIs or preventive measures and treatments.[74] Ethnic minorities, in particular, are vulnerable to health risks, such as reproductive tract infections and unwanted pregnancies, because of their limited access to sexual and reproductive health information and services.[75]

The situation in Lao PDR is not very different, although reported progress is encouraging. The Ministry of Public Health, UNICEF, UNFPA and the German Agency for Technical Cooperation (GTZ) have developed a standard set of curriculum materials on sexuality education, based on the life skills approach, that has been incorporated into the primary school curricula and upwards. Teachers have also been trained. Migrant women may have benefited from these efforts because the materials were included in the curriculum of eight teacher training colleges including in Luang Namtha, Luang Prabang and Xiengkuang provinces, areas with significant outmigration flows.[76] In 2009, a total of 855 schools provided life skills-based education. The effectiveness of these efforts, however, has been difficult to determine.[77] For this reason, it is unclear if young women or prospective women migrants have been adequately equipped with sexual and reproductive health knowledge.

There have been recent efforts in Cambodia to introduce sexuality education for young people. As such initiatives were introduced only in recent years and in selected provinces in the country, it is difficult however to draw any definitive conclusions on the extent to which they might have made a significant impact on the sexual and reproductive health knowledge of migrant women. With support from UNFPA to the Ministry of Education, Youth and Sports, a life skills education programme, including topics on HIV, reproductive health, gender and drug issues, is now targeting 14 out of 23 provinces across the country. The programme was implemented in 2,662 primary schools and, in 2010, a peer education approach was introduced, targeting 76 (of 1,471) secondary schools. In addition to this, some NGOs have initiated reproductive health education in selected districts of a number of provinces; these have generally not been sustainable due to resource constraints.

Information on access to sexuality education in schools in Myanmar was not available for the literature review but is likely to be limited, especially for those living in states bordering Thailand which is the area of origin for many migrant workers.

Availability of health facilities and social insurance mechanisms

Whether women have previously accessed reproductive health services in their places of origin is also likely to be a factor influencing whether or not they seek services in destination locations. None of the studies reviewed had explored this aspect. Generally speaking however, unmarried female

migrants are very unlikely to have accessed reproductive services in their places of origin as, where they exist, these services are almost always seen as targeting married, rather than unmarried, women.

The *availability* of reproductive health services does not necessarily ensure *access*. While knowledge and awareness are critical, the types of health care services available, provider attitudes and facility opening hours were amongst the most important factors that determined whether migrant women sought health care. Access to social insurance schemes that covered health costs was another key factor influencing the ability of migrant women to access services.

In Thailand, possession of the government health card enabled greater access to the health care system. In cases where migrants had changed jobs or moved away from the hospital at which they were initially registered, women usually ended up having to pay for health services.[78]

One of the reviewed studies in Thailand found that around 40 per cent of Shan women migrants from Myanmar had used family planning services at public hospitals or health centres, while an equal proportion did not know about the availability of such services and, hence, had never used them. Furthermore, a large proportion of migrants were not aware of the sexual and reproductive health services available in some hospitals or health centres.[79] Another study found an increase in the number of deliveries among pregnant migrant women in hospitals, in spite of the women having to bear the costs themselves, indicating awareness of the availability of certain health care services at least. This was evident in the provinces of Samut Sakhon and Ranong, where there were high concentrations of migrants.[80]

In Viet Nam, sexual and reproductive health services are available at commune health centres which serve rural women. However, the lack of health insurance has resulted in migrant populations having limited access to such services.[81] Access to health insurance is determined by residency status, but in the absence of a regulatory system to track the movements of migrants, they are unable to apply for health insurance in their destination areas. Instead, they have to return to their home village – where they are registered for primary health care – to secure permission to be referred to health centres near where they have relocated. In addition, because government health services operate during business hours, those unable to access health care services at those times end up using the more expensive private health care services. In

addition to time pressure, the costs of routine gynaecology checks negatively impacts on access to health services. A study cited in a 2009 report found that only 40 per cent of female migrants planned to have gynaecological check-ups.[82] Factories with health care facilities on site, while typically a good thing, can also operate against women migrants' best interest, such as when women are sent back to work even when they are unwell.[83]

The Social Security Organization could theoretically cover internal migrants in Lao PDR, although its application has so far been limited in terms of geographic coverage, applying only to Vientiane Capital and other urban areas. Migrants only receive coverage if they subscribe to this health insurance however, and so far very few have subscribed, leaving them vulnerable to health risks. They are also not eligible to subscribe to the health insurance scheme unless they have worked for at least three months. Women migrants working in the informal sector also have the option of applying for the voluntary Community-Based Health Insurance scheme, although this plan also has limited coverage so far, in 20 of the country's 143 districts.[84] The advantage of this plan is that the worker, plus her entire family, can be covered at the same time. For those not covered by either plan, maternal and child health services are reportedly available ex gratia, except for a small nominal fee for some aspects of health care.

The current Labour Law of Cambodia was passed in 1997 and the Law on Social Security Schemes for Persons Defined by the Provisions of the Labour Law was passed by the Parliament in 2002. The sub-decree concerning the establishment of a National Social Security Fund was adopted in 2007, and became fully functional at the end of 2008. None of the literature reviewed in Cambodia provided information however on whether migrant women have been able to avail themselves of the benefits provided by the scheme. Given the informal nature of much of the work migrant women are engaged in, this seems unlikely.

Service providers' attitudes

Service providers' attitudes have been found to be a critical factor in determining whether or not migrants seek health services. The way in which service providers treat women migrants influences uptake of services, especially because migrants are aware of their marginal status in their destination areas. Where service providers have negative attitudes or prejudices, especially towards those from specific employment sectors, these

attitudes have reportedly affected migrant women's decisions on whether or not to access health services. Stigmatisation and discrimination against migrant women appeared to be a common experience in the four countries where the reviews were conducted. This included stereotyping and labelling, as well as discrimination in health care settings.

In Viet Nam, for example, migrants were often associated with the "social evils" of HIV, AIDS and STIs.[85] Consequently, they were treated by local residents, as well as government authorities, with mistrust and unease.[86] This prejudice hindered migrants from seeking help when needed. Health care providers were also been found to blame women with STI symptoms, including migrants, for having poor personal hygiene, thereby discouraging them from seeking relevant treatment.[87] Health providers were also reported to show cultural prejudice and social disapproval of premarital sex and contraceptive use among young people, thus discouraging planned sexual activity, in spite of the willingness of young people to pay for contraception.

Sex workers from Myanmar working in Thailand also reported negative experiences. Literature reviewed described how they were treated rudely by health providers and translators and often encountered verbal insults and insensitive behaviour from doctors and nurses when discussing STIs.[88] Service providers also commonly perceived migrant workers as carriers of diseases.[89] Experiences were not altogether negative though. A survey of

users' satisfaction of sexual and reproductive health services among Shan migrant women found that 97 per cent were happy with the knowledge and skills of the service providers they relied on. About the same number (96 per cent) reported being satisfied with the attention and friendly service, and for the privacy of the examination room (95 per cent).[90]

In Lao PDR, reported factors influencing health-seeking behaviour included fear of authorities and insensitive service providers.[91] There was also a general perception that health providers were judgemental about migrant women, especially those who were unmarried and from an ethnic minority. As migrants are stigmatized and have often reported negative experiences at health care facilities because of service providers' insulting attitudes, some have turned to over-the-counter medication, including "Chinese medicines" frequently used to induce abortion.[92]

Perceptions of health care providers in the public health system are also critical to female migrant access to health care in Cambodia. One 2006 report noted that although 66 per cent of migrants had become ill since migrating for work, only 10 per cent had sought medical help.[93] Migrant worker concerns ranged from questioning the clinical competency of the health care workers, to the perceived superior attitude of health care workers towards rural people. As a result, 70 per cent of migrant workers turned to pharmacies with the intention of self-medicating, 14 per cent sought the services of private clinics, and 7 per cent used traditional medical treatments. There are inherent risks associated with use of unregulated pharmacies and private services.

Living and working conditions

The living and working conditions of women migrants have a bearing on whether they seek health care. Being newcomers to a city often means not knowing the local health care system or the location of health clinics. Thus, the social networks that women migrants form in the different stages of the migration process influence their access to sexual and reproductive health information and services. Within the migration context, these social networks often replace family and community support and are important because it is through such networks that women migrants receive sexual and reproductive health information, as well as emotional support, in the destination areas. There is scope for fostering such networks, although the literature reviewed provided few examples of how this might be done apart from through peer education initiatives.

In Viet Nam, women migrants working in the industrial zones reported not seeking health care services unless they had a very serious health condition that interfered with their ability to work. For live-in domestic workers, long working hours has been an obstacle to their visiting a clinic in the event medical care was needed.[94]

In Thailand, a study highlighted that the kind of work engaged in by female migrants tended to determine access to reproductive health information and services. For example, some work sectors were more isolating than others and women engaged in those sectors encountered barriers in seeking health

GOOD PRACTICES

A community house for migrant workers in Viet Nam

In Ha Noi, a community house for migrant workers was set up in a migrant-dominant commune by the Light Community Health and Development Organization and World Concern. Sexual and reproductive health information and services were available for women migrants. Peers were trained in sexual and reproductive health issues and helped other migrants negotiate the necessary referral processes to ensure they could receive relevant health information and services.

http://www.light.org.vn/light

Far Away From Home Club, Can Tho City, Viet Nam

Facilitated by a migrant worker support network, a peer education approach was used to empower migrant workers to protect themselves from HIV, and to access confidential health, social and legal services. Organised by a provincial multi-sector team led by the Dept. of Labour, Invalids and Social Affairs, local leaders were mobilised, thus ensuring the leverage to address sensitive issues, such as provision of condoms in public venues. The initiative also promoted development of HIV prevention policies with employers, and introduced penalties for non-compliance. Lessons learned were documented and shared with other partners, resulting in the decision to replicate the approach in other provinces.

http://data.unaids.org/pub/Report/2008/JC1567_vietnam_en.pdf

care information and services; outreach programmes also found them hard to reach.[95] Among domestic workers, general awareness of sexual and reproductive health issues was found to be less compared with factory workers and those working in entertainment venues. Similarly, women engaged in agricultural work often lived and worked in rural and isolated communities. Among this group, the long distance between their workplace and a health centre proved to be a barrier. Factory women also had their share of barriers: the same study found that 85 per cent of migrant women from Myanmar that were engaged in factory work, self-medicated regularly with traditional or herbal remedies.[96]

Factories that provide accommodation also posed an obstacle in Thailand for many female migrants because they were less free to leave. Those migrants living outside the factory compound had relatively greater freedom of movement, although the long working hours left little free time. While local health programmes targeted factory women more easily compared with those working in the domestic and agricultural sectors, the demands of factory work have constrained women migrants in exercising their rights to health care.

Although migrant sex workers are often targeted for health care and HIV prevention activities by government agencies and NGOs, many reportedly sought help only when their health problems became critical. In some cases, abuses by police, or unhelpful laws – such as those criminalising the carrying of condoms by women, or misguided anti-trafficking laws – resulted in women delaying seeking treatment.[97]
Occupational demands also made it difficult for women to find time to seek a regular STI check-up.[98] In addition, Thailand's Ministry of Public Health policy to close down and transfer STI clinics to public hospitals in recent years has disadvantaged sex workers needing preventive care and treatments, due to fear of being treated prejudicially by government staff.

Garment factory workers in Lao PDR and Cambodia experienced similar working conditions as women working in the same industry in Thailand and Viet Nam. Long working hours were a barrier to accessing reproductive health information and services. In addition, public health services were only open on weekdays. Some factories provided health care on site, although the services provided in these facilities varied in quality.[99] It was reported in Cambodia that factory management limited women migrants' access to these health services, possibly calculating the costs involved.

Stigma, xenophobia and social exclusion factors

Migrants often encounter stigma and marginalization in their work destination. The status they have in destination communities has a bearing on whether or not they decide, or are able, to access health services and the quality of health care available to them. The lack of regulatory policies and relevant legislation to enable their access to sexual and reproductive health services has also reinforced their marginal status in some instances. In others, criminalizing certain types of work engaged in by female migrants has increased their sexual and reproductive health vulnerability.

For example, in some countries the 100% Condom Use Programme has been misused by government authorities, with negative impacts on sex workers' rights and their ability to protect themselves from violence. Evidence suggests that enforcement mechanisms are often used to target and harass individual sex workers. In some cases, coercive methods such as forced HIV testing, deprivation of income and health care, and harassment and extortion have been recorded. Numerous laws and practices aimed at preventing sex work also undermine HIV programming.[100]

In Viet Nam, women migrants in cities such as Ha Noi and Ho Chi Minh City have experienced social and geographical segregation because of the limited affordable residential choices. This poses a challenge for sexual and reproductive health programmes to reach out to them. However, the longer migrants stayed in the destination area, the more likely they received sexual and reproductive health information and accessed health care services.[101]

GOOD PRACTICE **Better Factories Programme, Cambodia**

At the Factory Gates (2009), an eight-episode series of comics addressing a range of sexual and reproductive health issues, was produced by the International Labour Organization. Socially and culturally relevant stories, presented in an attractive medium, these comics targeted both factory women as well as their employers, focusing on migrant rights.

Better Factories Cambodia (2009), At the Factory Gates, Phnom Penh: International Labour Office

Most reproductive health-related policy and strategy documents in Viet Nam, according to the reviewed literature, have stigmatized migrants and associate them with social problems. For instance, the Population Strategy 2001–2010 associated migrants with negative impacts on development, while the Reproductive Health Strategy 2001–2010 made no reference to them at all. In spite of most internal migrants being young and thus vulnerable to social and health risks, the Master Plan for Youth, or the Youth Law, does not mention them either.[102] Moreover, the Government of Viet Nam has demonstrated bias against migrants by making it more difficult for them to gain permanent residence in large urban areas, fearing that migrants add to the problems found there. Sex workers are the most marginalized of migrants because the laws criminalize their work. For this reason, sex workers experience severe disadvantages – they are frequently arrested by the police and are detained in "administrative detention centres". Out of fear of being arrested, sex workers typically have not responded to safe sex promotion programmes.

In Cambodia, the Law on Suppression of the Kidnapping and Trafficking of Human Persons and Exploitation of Human Persons launched in 1996 and strengthened in 2008 penalizes women working in venues associated with sex work, because of the conflation of trafficking with sex work. This has resulted in the reluctance of women migrants working in massage parlours and entertainment venues to seek medical treatment because of fear they would be identified as a sex workers. Additionally, providing reproductive

health information to sex workers has also become illegal, according to the precise terminology of the law.

Laws criminalizing sex work in Lao PDR have also increased the vulnerability of sex workers. The Penal Law describes sex work as a criminal offence, with penalties ranging from short prison sentences to re-education and small fines.[103] The stigma and marginalization experienced by this group contributes to their poor self-image and lack of confidence in the legal system,[104] also influencing whether or not they seek medical help. A sexual behaviour study conducted in Vientiane revealed that sex workers did not access the general health care services out of fear of discrimination and social stigma.[105] They were also reluctant to approach the relevant authorities and health care facilities even in situations of abuse.

In the documented literature on Myanmar migrants in Thailand, stigma and marginalization were not flagged as factors influencing health-seeking behaviours, except in the case of migrant sex workers. Instead, legal status and financial considerations were found to be more important. For instance, a study (2007–2008) of Shan women in Chiang Mai found that equal numbers of documented (85 per cent) and undocumented (82 per cent) migrant women accessed health care services, despite their migrant status.[106] Documented migrants, however, have the advantage of possessing a government health care card that enables them to seek assistance at the public hospitals; their undocumented counterparts often choose the private clinics where they have to pay a fee for the health services. In either case, the choice of reproductive health facility depends on the availability of health care services.

GOOD PRACTICE

MAP Foundation, Thailand

In 2000, the NGO MAP Foundation helped develop a ten-step guide for victims of gender-based violence. Entitled the Automatic Response Mechanism (ARM), this tool was translated into several migrant languages. Grass-roots women's groups in different locations were trained on the ARM. Migrant women gained confidence and skills to support women survivors of abuse, and they themselves also became more assertive in accessing health care.

http://www.mapfoundationcm.org/


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CHAPTER FOUR

Socio-cultural Impacts

In addition to structural considerations, socio-cultural factors – including gender norms and attitudes, cultural notions and taboos, language barriers, and traditional medical systems and treatments – are significant aspects that enable or hinder migrant women's access to health care information and services.

Gender norms

Despite the perception that women in the Mekong region countries generally have more equal relations with men than women in other parts of Asia, unequal gender power relations embedded in local cultures affect the health-seeking behaviour of women migrants. Many have been found to either hold back on seeking relevant health care services, or to defer certain decisions in the favour of men, including their husbands, in such situations as condom use or family planning, thereby increasing their vulnerability to sexual and reproductive health risks. For example, a study conducted among Shan women migrants in Thailand, noted that about 65 per cent of respondents reported they never discussed family planning with their husband or partner, even though the onus of preventing pregnancy rested on them.[107] Additionally, women migrants were unable to assert their reproductive rights if they did not want any more children, lest they go against the wishes of their husbands. Among married women migrants in the Mae Sot area in another survey, spousal approval had a greater impact on use of contraception than their level of education, income, duration of marriage or the woman's desire to have additional children.[108]

Cultural notions of a "good" woman have also hindered women migrants from using contraception. In Cambodia, the purchase of condoms among women is linked to personal

Aidan Dockery / UN Viet Nam

embarrassment and fear of gossip. There is an obvious double standard in which men are granted sexual autonomy and women are expected to be sexually inexperienced before marriage. Because virginity in unmarried women is prized, premarital sex is frowned upon among girls more than boys.

That women are expected to be passive, maintain control, act within certain boundaries and have limited equality to men is the prevailing gender norm in rural areas in Viet Nam and thus influences their sexual and reproductive health outcomes. Women's choices regarding sexual and reproductive health are usually made within the boundaries of a socially constructed femininity, in which a high value is placed on female virginity; women are expected to be sexually innocent until marriage, thereby curtailing their exercise of their rights by ensuring safe sex choices or in accessing reproductive health services. Young migrants, in particular, have reported the fear of being discovered as sexually active before marriage[109] and thus are less likely to purchase condoms or seek medical care.

Similar findings were reported in the Lao PDR. Gender norms dictate that daughters, especially older daughters, should provide for the family. Women are expected to behave with propriety, including when they move away from home for work. Women working in factories struggled against negative images of female migrant workers, and feared being associated with sex work.[110]

Language and communication issues

Language barriers have been recognized as an important factor constraining migrants from accessing health information and services. This was noted to be particularly the case among Burmese migrants in Thailand; in the other Mekong countries, migrants generally appeared to represent the majority population, or ethnic minority people who speak the national language.

Due to language barriers, Myanmar migrant women in Thailand sometimes opted for traditional health care when they had health problems, including those relating to sexual and reproductive health. In one study, Shan migrant women expressed difficulties in communicating with Thai medical staff because they could not speak or understand Thai and thus could not describe their symptoms.[111] Women migrants also tended to use their own set of assumptions to explain any abnormal symptoms they were experiencing, thus reflecting their own cultural interpretations of illness. In this case, the

GOOD PRACTICE

Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT) Programme, Phase 1

This project aimed to reduce the incidence of HIV through prevention measures targeting migrant workers and by strengthening the health care system. Outreach teams consisting of at least one migrant health worker and one Thai field worker were established. Migrant health workers were recruited from the predominant ethnic groups of the migrants and received intensive training in HIV and reproductive health issues. A network of migrant volunteers was also recruited to promote behaviour change communication interventions among hard-to-reach migrant groups.

The migrant health workers and volunteers played a key role in providing translation support at the hospitals frequented by migrants. Drop-in centres and mobile health clinics were also established and provided services at times convenient to migrant workers. These facilities helped bridge the gap between migrant communities and local health services.

Mahawan, L., Talawat, S., Sawasdipanich, W., Riewthong, U., Chaitha, I., Saisaengjan, C. (2010). Best Practice for HIV/AIDS Response in Thailand 2008 -2009. National AIDS Management Centre, Ministry of Public Health Thailand.

absence of translation support or migrant health volunteers to assist them in the public hospitals prevented them from further seeking sexual and reproductive health information and services. Another study found that among migrants who stayed longer in the destination areas and became pregnant, there was a preference to deliver in a hospital because of the ability of migrant women to speak some Thai, although convenience of travel and the limited availability of traditional birth attendants were also significant factors.[112] However, it appeared that some of these women wrongly assumed that delivery in a hospital was one way in which they could secure Thai nationality for their newborn.

In Lao PDR, the lack of trained health personnel from the ethnic minority groups was reported to severely curtail health service use among ethnic minority women. The situation has led to many women among the minority groups buying over-the-counter medication or consulting traditional medical practitioners.[113] The literature reviewed did not specifically mention to what

extent, if any, language barriers were a factor that affected ethnic minority migrant women. It is likely that the majority of those that migrate to the larger urban areas already speak Lao.

Traditional health beliefs, practices and treatments

Dependence on traditional self-treatments and a belief in traditional explanations regarding health also influence the ability of migrant women to understand the seriousness of certain medical conditions and the necessity to seek immediate treatment. A study amongst migrant workers in Mae Sot, Thailand, found that the rate of women seeking traditional treatments for sexual and reproductive health problems was nearly twice as high as those seeking Western-based medical treatments available in hospitals and clinics, indicating that levels of trust in conventional or allopathic methods of treatment were relatively low. Herbal or traditional medicines were often sought, especially in association with practices around childbirth. Familiarity and availability of alternative remedies may also explain the high rates of use of these treatments.[114] Several studies also documented that 60–70 per cent of the female migrant respondents from Myanmar sought the services of a traditional birth attendant for help with an abortion or resorted to self-inducing an abortion, using techniques such as massaging the uterus, ingesting traditional herbs or alcohol, inserting a stick into the uterus or injecting medicines into their body[115] – methods that led to complications.[116]

Traditional health beliefs and practices in Viet Nam also have influenced the use of health services and treatment regimes. Especially among the rural and uneducated population, illness is thought to be caused by a lack of balance in the spiritual life, and thus there is a preference for natural remedies. Conversely, Western medicine is thought to be "invasive", with long-term side effects, but providing only symptomatic relief.

Cultural values, beliefs and taboos

Cultural values, related to status and how an individual presents herself in society, also affect health-seeking behaviour. The concept of preserving "face" by not bringing shame onto oneself or one's family is critical in shaping sexual and reproductive health behaviour and outcomes. In the region, the fear of being stigmatized as an individual who deviates from societal norms continues to be strong. Conformity to societal norms in this case has negative

consequences, especially when decisions made are contrary to the interests of a female migrant, which, in turn, results in a compromise of her health.

Reputation and public opinion are considered to be very important in Viet Nam. Individual behaviour reflects on families, and there is a strong desire to maintain face and avoid stigmatization. The fear of stigma and "loss of face" hinders seeking medical help. Female migrants also fear that through their social networks, word about their illness will get back to their home village. In this case, migrants would rather bear their misfortune than bring shame to their family.

Cultural notions of fate also tend to be a strong factor influencing how people in Viet Nam view unwanted pregnancy, HIV and AIDS, especially in rural areas and among the uneducated. Because of a belief in fate, people have distanced themselves from taking responsibility for making the right choices related to their sexual and reproductive health, or risky behaviours.[117] Moreover, Vietnamese culture reinforces stoicism and suffering, including when facing pain and disease. In such cases, seeking medical help for physical pain was reported to have been delayed, or considered inappropriate.[118] Because some health problems, such as STIs, HIV or AIDS, are considered "social evils", women with infections are often reluctant to go for health checks or even to seek immediate treatment.

Fear of embarrassment and social rejection has kept women in Viet Nam from approaching health centres for contraception.[119] In fact, the fear of losing face and harming the family reputation was stronger than the fear of unwanted pregnancy or of sexual and reproductive health risks, especially impacting on unmarried migrants and sex workers.[120] In addition, because condoms are associated with "illicit or bad" sexual behaviour in Viet Nam, many people believe that by not using condoms they are not engaging in social evils, and are thus immune from becoming infected with HIV. As a result, there continue to be misconceptions on how HIV is transmitted. For example, factory workers linked HIV with "easy-going sex" and having multiple partners. The fact that discussing sex is taboo for women, religious followers and rural people, has had an impact on how these groups access sexual and reproductive health information and services.

In the Lao PDR some ethnic groups have different practices regarding premarital sex from the majority population. The Khmu, Thai Deng and Akha ethnic groups are traditionally less sexually restrictive, and premarital sex is accepted in certain circumstances. Matrilineal kinship groups are reportedly also more tolerant of premarital sex than patrilineal groups.

Literature reviewed showed that in the northern provinces, women from the Khmu and Thai Deng ethnic groups were more commonly found among sex workers than women from other ethnic groups, which could be a reflection of traditional cultural norms. Consequences of different norms vary for each group: on the one hand, cultural taboos against premarital sex, which prevail among the majority Lao Loum population, may promote abstinence and reduce the threat of HIV, and cultures that shame certain sexual behaviours may be less open to discussion on health risks and acceptance of safe sex practices.[121] Conversely, in cultures that are tolerant of premarital sex the vulnerability of people to various health risks is increased.

Among the Khmu in northern Lao PDR, premarital sex is not taboo, although there are clearly prescribed traditions surrounding when and where such activity may take place. Within the village, each house is protected by customary spirits, and it is understood that no sexual impropriety should take place within the home for fear of offending these spirits. Young people thus commonly engage in premarital sex outside of the home. Researchers described how these traditional beliefs could be seen to support the increased involvement of women in the service industry because local beliefs, to some extent, privilege sexual interaction away from the home.[122]

GOOD PRACTICE **Sewing a Healthy Future Project, Cambodia**

A health education programme supported by CARE was established in factories, and workers were recruited as health volunteers. They played a critical role in setting up informal peer networks through which sexual and reproductive health information was disseminated, and factory-based health promotion activities were supported.

CARE (2005), Sewing A Healthy Future 11-A Midterm Evaluation Measuring The Sewing A Healthy Future Project Coverage and Behaviour Change Outcomes In Intervention and Non-Intervention Forms, Phnom Penh: USAID

The notion of trusting one's "sweetheart" in Cambodian culture also has served to compromise safe sexual behaviour among female migrants.[123] Some entertainment workers, especially female karaoke workers, may have multiple sex partners at the same time, exchanging sex for money. Usually in such situations they report using condoms most of the time. However, because they feel they can trust their "sweethearts" (boyfriends) as sex partners, many have reported not using condoms consistently and also engaging in other high-risk behaviour at the same time, such as regularly consuming alcohol and using illicit drugs.

Social networks

The role of social networks was found to be a critical factor with the potential to influence the sexual behaviour and health seeking behaviour of female migrants in all four countries where the reviews took place. In Lao PDR, for example, female migrants rely on their network of friends for personal and emotional adjustment, especially in difficult situations. Information on sexual and reproductive health services (such as how to obtain an abortion) gets relayed through social networks or, in the case of sex workers, *mamasangs* (women who run sex work establishments). The reports from all four countries described how the sex worker community provides critical support for women who sell sex. This situation is similar for other migrant groups. In Lao PDR it was reported that strong social networks have enabled women to come out of abusive relationships by giving them security through membership of a group, thus empowering them to seek help.[124]

While there are positive consequences to having strong social networks, a study in Ho Chi Minh City found that women migrants had also been exploited by people within their social networks. In some cases, in fact, the network relationship led to women entering sex work.[125]

Evidence of how social networks are significant in migrant behaviour was also found in Cambodia. A study described how when young people migrated to an urban area, they were more vulnerable because they had moved away from the support and control of their parents and community. Traditional gender norms and religious and social values once upheld in the rural areas tended to lose their significance for these women. Factory workers relied on information from their friends and through their social networks to hear about other job opportunities, and tended to frequently 'move on' to other workplaces, including those in the entertainment industry. In such cases, friends sometimes encouraged them to engage in sexual relationships with men in the destination area. Reaching out to these women through sexual and reproductive health programmes becomes difficult, especially when they are too embarrassed to admit that they are engaging in sex.[126]

Other literature also highlights the key role that organised community-based organisations can play in supporting marginalised groups such as migrant workers. Building on, and working through existing migrant networks, such groups provide support services and also work to foster enabling social, political, legal and financial environments.[127]

GOOD PRACTICE

The Coordination of Action Research on AIDS and Mobility (CARAM)

CARAM Asia branch has been working on issues of migrants' rights and health since 1997. The network channels its work through three task forces: Migrant Health and HIV; Migrant Labour Rights; and Migration, Globalisation and Development. The task forces carry out participatory action research and advocacy on issues related to migrants' health and well-being, ranging from HIV to migrant workers' rights.

UNAIDS, 2011. HIV in Asia and the Pacific: GETTING TO ZERO

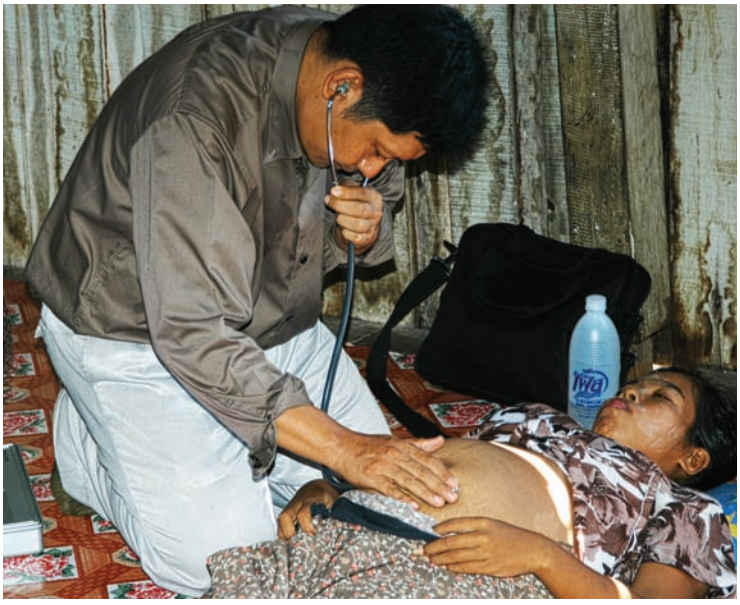
CHAPTER FIVE

Conclusions and Recommendations

5.1 Strengths and gaps in the research

Scope of research literature available

In three of the four countries reviewed – Cambodia, Viet Nam and Thailand – substantial quantitative and qualitative studies on women migrants have been conducted. However, a large-scale baseline and project impact survey with gender disaggregated data that explores such issues as the situation of HIV and STIs, contraceptive use and access to maternal health care services appears to have only been conducted in Thailand, with respect to international migrants.[128] In all four countries, the reviewed literature found that smaller, qualitative studies had not produced sufficient data to inform policy making. Larger studies, however, had not addressed the socio-cultural links with sexual and reproductive health, which was the focus of the reviews. There was very little



relevant material available at all in Lao PDR on internal migrants. In general, available literature on migrants did not address socio-cultural factors linked with sexual and reproductive health in any of the countries reviewed.

Recommendations were made that more qualitative and quantitative research should be conducted in all four countries, with an emphasis on the behaviour and identified needs of internal migrants. Studies should include a focus on socio-cultural, as well as political and economic factors, that influence decisions to migrate. Different stages of the migration journey should be examined, along with the impacts these have on sexual and reproductive health outcomes, health-seeking behaviour and barriers to accessing services. Longitudinal studies that follow subjects over time should be conducted to provide more reliable information on migration populations. The robustness of national surveys should be improved, and data collection should be systematic and uniform for comparative analysis.

Many studies reviewed focused on small geographical areas and were limited in scope. To produce data useful for policy making, it was recommended that research should be conducted that has a wider geographical focus and explores the experience of migrants in all kinds of occupations. Due to the high mobility reported between different types of employment, the tracking of migrants may be difficult – but would not be impossible, given the existence of strong social networks. Little documented research appears to focus on the situation of domestic workers who remain a largely 'invisible' group of migrants. This very invisibility makes them potentially very vulnerable. More information is needed on those working in this sector.

Focus on different identities of migrant women and gender-related aspects

The Viet Nam literature review noted that migrant women do not constitute a homogenous group. The review author reported that few of the materials they reviewed looked at the situation of adolescent migrants, or the implications their age and often unmarried status might have on their sexual and reproductive health, or on issues around accessing services. Given that young women constitute a large proportion of migrants, it was recommended that more attention should be paid to these factors.

The nexus between ethnic minority cultures, beliefs and practices and migration also should be further explored, especially in Lao PDR and Viet Nam, where significant numbers of minority women are migrant workers.

Recommendations were also made for more research on the impact of gender norms and relations on the sexual and reproductive health of women migrants. The Cambodia and Viet Nam review papers also include recommendations for collecting data on the role religion plays in influencing gender norms and sexual and reproductive health behaviour of migrant women.

Research should address broad aspects of reproductive health, not only STIs and HIV issues

Existing research and interventions focused almost entirely on STI and HIV prevention among migrant women. To a certain extent this is justified. Some migrants may engage in sex work – either directly or as a side-line activity to supplement other income. However, the majority of the female migrants in the reviewed literature were employed in low-risk occupations, such as factory work and domestic work. The literature indicated though that there is high mobility between types of employment, such as from factory work to sex work, and that low income levels among female migrants may encourage certain high-risk sexual and reproductive health behaviours, thereby placing them at risk.

However, the focus on STI and HIV prevention means that migrant women's other identities – as girlfriends, wives and mothers – have generally been neglected. It was recommended that research should be conducted that addresses the broader aspects of reproductive health and associated socio-cultural factors, including contraceptive needs, unwanted pregnancy and unsafe abortion, as well as ante-natal and post-natal care and safe birthing facilities for those requiring such services. Although violence against migrant women was reported in some of the literature reviewed in each country, the very limited data on this means that further research is urgently needed on this area also.

Understanding of sexual and reproductive health of male migrants

The focus of these four literature reviews has been female migrant workers, which prompted the review authors to recommend that corresponding research should be conducted to look at socio-cultural factors impacting on male knowledge, attitudes and practices related to sexual and reproductive health and the links to women migrants' health. In some destination communities, male migrant attitudes impact on female migrant behaviour because of the relationships that are formed. In Cambodia, for example,

perceptions of masculinity changed among men, depending on the social context in which they found themselves, or on whether they were in a marital or non-marital relationship. These factors, in turn, determine sexual behaviour.

5.2 Strengths and gaps in programming

Programme/project innovations

In the countries where the reviews took place, a number of initiatives have been introduced to address the specific needs of migrant women in response to their socio-cultural differences. In Thailand, for example, information and educational materials were developed in the languages of migrants. Additionally, migrant health assistants performed a valuable role in bridging the gap between migrant women and health staff, including translation services. Service providers in public health facilities in some provinces with high numbers of migrant workers were trained to provide "migrant-friendly" services.[129, 130]

In Viet Nam, the use of "indirect channels", such as owners of boarding houses, heads of migrant groups, pharmacists and health care staff, media and sub-district notice boards, have been successful in providing reproductive health information to migrant women. In Thailand, the establishment of health clinics, including mobile clinics and drop-in centres in migrant communities are widely regarded as having led to positive outcomes. Peer education and support through migrant networks at community level, or through the workplace, were also frequently cited as successful modalities for reaching women.

In Lao PDR some training has been conducted in one facility in youth-friendly service provision, and a referral network was established.[131] Additionally, outreach workers have been successful in conducting HIV awareness and prevention interventions in sex worker communities. An initiative was also described wherein a beer company that employed beer promoters (who are often migrant women) had taken special action to protect female staff from potential harassment from male clients. The company disallowed female beer promoters to sit, drink or eat with clients (so as to minimise social contact and potential for unwelcomed sexual advances), and provided transport to and from work for staff (to protect them from sexual harassment or violence).[132]

In Cambodia, a series of comic materials with relevant information on a range of rights issues targeting migrant factory workers were developed in an accessible medium that was attractive to migrant workers.[133] Another initiative described did not specifically target migrant workers, although they would fall within the target audience: this was an interactive radio programme that included talk shows and phone-ins where young people could raise and discuss issues relating to sexual and reproductive health. The same NGO[134] also produced television soap operas that highlight the tension between tradition and modernity in beliefs, norms and values as reflected in the changing practices of sexually active young people. Also in Cambodia, successful peer education initiatives had been introduced in factories engaging migrant women in health promotion activities.[135]

Programme/project weaknesses

Uneven and limited reach: As previously noted, recommendations were made that programme interventions should be expanded beyond STI and HIV awareness raising and prevention activities to include broader aspects of reproductive health, addressing contraceptive needs, unwanted pregnancies and unsafe abortion, need for pre and post-natal care and assisted deliveries

for pregnant women, and also including gender-based violence and employer abuse of women migrants. The specific needs of HIV positive migrant women were also not addressed in the literature reviewed.

Interventions should target women migrants in both large garment and entertainment establishments, as well as women working in smaller establishments. Attention should also be paid to the far less visible domestic workers. Programmes should be expanded beyond the specific provinces and areas where there is a high concentration of migrants to those areas where migrants are fewer and less visible.

All four of the review authors recommended that programmes/projects should specifically target young and unmarried women migrants and that health service providers should be trained on youth-friendly service provision and encouraged to treat migrants with respect, irrespective of their choice of work.

Programmes/projects should recognize gender-based power relations. Recommendations were made that gender power relations should be taken into consideration in programme design. In Thailand, for example, the review author recommended that male migrants should participate more in sexual and reproductive health programmes, and that family planning programmes run by NGOs and public health agencies should take into account power relations between males and females. Additionally, a need was identified to recognize the important role of female health workers and migrant health assistants in facilitating greater access to sexual and reproductive health information and services among female migrants. A recommendation in all four reports was that higher priority should be given to addressing the gendered aspects of violence.

Sustainability: The sustainability of initiatives appears to be a challenge. In Thailand, for example, sustainability of certain initiatives was linked to the retention of migrant health assistants. In some cases, those employed moved on because they felt insecure due to their illegal status in the country; others ended up finding alternative types of employment with more competitive salaries.

The fact that most programmes/projects are donor driven also has a negative impact on sustainability. The Cambodia and Viet Nam reviews included recommendations that governments and workplace establishments such as

factories might consider strengthening and managing their own sexual and reproductive health programmes through partnerships with international organizations and NGOs responsible for providing technical assistance. To some extent, this approach has been successful in Thailand where international organizations have piloted services for migrants within public health facilities with the intention that the government would eventually take over the management and funding.

In all four reports the challenge of making peer education initiatives sustainable was mentioned, given the often high level of mobility amongst migrant workers and the high turnover of employees in certain establishments.

Evaluation: All four reports noted that very few interventions had been evaluated. This made it difficult for the authors to identify evidence-based 'good practice'. Examples included in the reports were therefore mostly based on anecdotal evidence, rather than on documented, measurable achievements.

5.3 Recommendations

The following recommendations are divided into three components – advocacy, knowledge sharing and competency building – and are addressed to specific audiences. They include recommendations from both the authors that conducted the literature reviews, and those who reviewed the reports.

POLICY ADVOCACY

Government and policy makers

- All relevant government policies should include reference to migrant workers and should mention the specific needs of female migrants, including their right to protection from violence.
- Health policies should address the sexual and reproductive health needs of women, men and adolescent migrants, including rights to protection from violence.
- Holistic health services that provide for the full range of migrant women's reproductive health needs should replace the current narrow focus on STI and HIV prevention.

- Gender dynamics should be taken into account when formulating policies in relation to migration.
- The positive role of migrant health workers should be recognized in relevant laws and policies (Thailand).
- Affordable health insurance should be made available for all migrants, irrespective of type of employment, so they can access services in destination areas.
- Sexual and reproductive health information should be integrated into the design of health, education and development programmes at the community, district and provincial levels in areas of high out-migration.
- School curricula should be strengthened to include sexuality education.
- In cases where it is not available in the national contraceptive mix, emergency contraception should be made available to address the prevalence of unsafe abortion.
- Campaigns should be launched against violence and other forms of abuse in the entertainment and other sectors, and owners and managers should be held accountable for abuses committed against workers.
- While recognising the specific needs of those engaged in 'high-risk' employment sectors, attention should be paid to migrant women in all forms of employment because of the frequent mobility between sectors, including movement from jobs seen as being 'low risk' to those seen as 'high risk'.

Owners of bars and entertainment venues, and factory management

- Employers should ensure easy access to sexual and reproductive health information and health services for employees so that migrant workers' health is not compromised by lack of access or time constraints.
- Clinics should be set up in factories, or referral systems established with external service providers.
- Consistent condom use should be promoted.
- Special efforts should be made to protect women from health risks and from violence in the workplace through collaboration with worker's associations, law enforcement officers and service providers.

Local authorities

- Reproductive health information and life skills should be introduced into programmes in both migrant origin and destination areas.
- Community-level organizations, including religious groups, could be engaged by local authorities to help facilitate the social integration of migrants.
- Coordinating mechanisms should be established with law enforcement officers to facilitate women migrants' access to justice.

Donors and the United Nations

- Governments should be encouraged and supported to address migrant rights in all relevant policy and programmes.
- Internal migrants' reproductive health needs should be incorporated into large-scale development initiatives, and should address not just communities within their immediate radius, but also those within the broader orbit once construction is completed (Lao PDR).
- Workers and employers organisations should be supported to promote and protect migrant workers' rights to health, including sexual and reproductive health.
- Ministries of Health should be encouraged to support the introduction of migrant-friendly service provision, including for unmarried and young migrant women.
- Funding should be channelled towards research on migration, including the socio-cultural links with sexual and reproductive health.

NGOs and other actors

- Media should be encouraged to promote positive images of migrants and their contribution to a country's economic development rather than perpetuating negative myths about migrants.
- Migrant social networks in destination areas should be supported to distribute sexual and reproductive health information as well as condoms and contraceptive commodities.
- Migrant networks could be supported to empower female migrants through the establishment of support groups focusing on addressing issues of importance to migrant women, including reproductive health and protection from violence.

KNOWLEDGE BUILDING

- Research on a range of issues related to migrant women and their access to sexual and reproductive health information and services, in both their places of origin and destination, should be undertaken. The findings should be used to:
  - inform policy development, including relevant health and migration policies, insurance schemes, formal and non-formal education etc.
  - inform curricula content for upgrading the training or skills of health service providers and others, such as social welfare providers
  - strengthen law enforcement through the promotion of employees' rights in workplaces and also for sex workers
  - inform the development of services to address the needs of migrant women who experience violence

COMPETENCY STRENGTHENING

- Sexual and reproductive health committees, with representation from workers, should be created within the entertainment sector and in factories to serve as a platform for distributing information on sexual and reproductive health.
- The competency of health service providers, migrant health workers and volunteers should be strengthened to understand gender dynamics and socio-cultural influences related to sexual and reproductive health.
- Training should be provided on counselling and culturally sensitive, migrant-friendly, non-discriminatory health provision, addressing issues such as client confidentiality, stigma and discrimination.
- Migrant workers should be provided with appropriate and culturally sensitive behaviour-change communication and IEC materials that provide information on sexual and reproductive health issues and the availability of services, in acceptable formats/medium.
- Public health facilities should be strengthened to provide outreach programmes that target hard-to-reach migrant groups living and working in remote and isolated areas and sectors.

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