Self-Care & Health Care:
How migrant women in the Greater Mekong Subregion take care of their health

Mekong Migration Network (MMN)
April 2015
Supported by the United Nations Development Programme
Self-Care & Health Care:
How migrant women in the Greater Mekong Subregion take care of their health

© Copyright of the Mekong Migration Network, April 2015

Published by:
Mekong Migration Network
P.O. Box 195, Chiang Mai University, Chiang Mai 50202, Thailand
Phone/Fax: (66)53 283259
Email: info@mekongmigration.org
Web: www.mekongmigration.org

Cover Design: Wichai Leesawatwong
Cover Photo: © Centre of Research and Consultancy for Development (CRCD),
Southern Institute of Sustainable Development (SISD)
Printed by: Wanida Press, Chiang Mai, Thailand

Supported by the United Nations Development Programme
Table of Contents

Acknowledgements 5

Introduction 7

Methodology, Participants and Scope 8

Context Setting: Migration and Health in the GMS 12
  Brief Background on Migration in the GMS
  Overview on Health Issues in GMS Countries

How Migrant Women Take Care of Their Health Without Doctors 15
  What is Self-Care? A health resource for migrant women
  Continuum of Care

Decisions Women Make: Choosing among options on the health care continuum 21
  Quality of Health Care: Effectiveness and scope
  Women Prioritise Health of the Breadwinner – Whether themselves or others
  Leaving Problems Untreated or Returning Home for Treatment
  Young and Healthy Migrant Women

Underlying Factors that Affect Migrant Women’s Self-Care 27
  Living and Working Conditions
  Information on Health
  Time
  Money
  Other Factors: Stress, diet, family support

Underlying Factors that Affect Migrant Women’s Access to Doctors and Hospitals 37
  Documentation
  Isolation
  Language
  Bureaucracy
  Time
  Cost
  Discrimination
  Workplace Policies

Policies on Migrant Health Care in the GMS 48
  Thailand as a Destination Country
  China as a Destination Country
  Cambodia as a Country of Origin
  Cambodia as a Destination Country
  Lao PDR as a Country of Origin
  Lao PDR as a Destination Country
  Myanmar as a Country of Origin
  Vietnam as a Country of Origin
  Regional Policies and Frameworks on Migration and Health
Self-Care & Health Care

Sexual and Reproductive Health Issues Migrant Women Face in the GMS 67
  Contraceptives 67
  Abortion 68
  Pregnancy & Birth 69
  HIV/AIDS 71
  Other Sexually Transmitted Infections 72
  Gender-Based Violence (GBV) 73

Conclusion 74

Recommendations 75
  Recommendations for National/Local Governments 75
  Recommendations for NGOs 77
  Recommendations for Health Care Providers, including Pharmacists 77

Annexes 79
  Annex 1.  Project Partners 79
  Annex 3.  Acronyms 89
Acknowledgements

Firstly, we would sincerely like to thank all the migrants who contributed their valuable time to share their experiences and thoughts for this project. We would also like to thank all the other key informants including local authorities, health professionals and NGO/community workers for their insight. We would like to express our gratitude to specific people and organisations for their work in carrying out the research and finalising the report.

The following people led country research teams:

1. Burma/Myanmar – Ms. Naw Hel Lay Paw from Women’s Galaxy, and Sex Workers in Myanmar Network (SWIM Network)
2. Cambodia – Mr. Sokchar Mom and Ms. Phoebe James from Legal Support for Children and Women (LSCW)
3. China – Dr. Deng Rui and Ms. Chen Xue from Yunnan Health and Development Research Association (YHDRA)
4. Lao PDR – Dr. Kabmanivanh Phouxay and Ms. Oulavanh Sinsamphanh from Faculty of Social Sciences, National University of Laos
5. Thailand – Mr. Brahm Press and Ms. Narnisi Jate from MAP Foundation, and Ms. Elizabeth Cameron from EMPOWER Foundation
6. Vietnam – Dr. Huynh Thi Ngoc Tuyet and Ms. Nguyen Thi Minh Chau from Centre of Research and Consultancy for Development (CRCD), Southern Institute of Sustainable Development (SISD)

Members of the research advisory team provided valuable inputs at various stages of the project:

1. Dr. Rosalia Sciortino Sumaryono, Institute for Population and Social Research (IPSR), Mahidol University
2. Mr. Brahm Press, MAP Foundation
3. Ms. Elizabeth Cameron, EMPOWER Foundation

MMN interns carried out desk research in addition to that carried out by respective country research partners:

1. Ms. Charlotte Gautier
2. Ms. Phawika Rueannoi

The following researchers from Center of Research and Consultancy for Development (CRCD), Southern Institute of Sustainable Development (SISD) analysed the quantitative data collected by respective country research partners:

1. Mr. Nguyen Quoc Dinh
2. Ms. Nguyen Thi Bao Ha
3. Ms. Nguyen Dang Minh Thao
Members of the MMN secretariat ensured the successful implementation of the project. Their tasks included overall coordination of the project, developing a research design and finalising the interview questionnaires based on inputs from the project partners, providing quantitative analysis to the interview results submitted by the country research teams, editing and layout:

1. Ms. Reiko Harima
2. Ms. Hkun Sa Mun Htoi
3. Ms. Gabrielle Curtis
4. Ms. Omsin Boonlert

Ms. Rebecca Napier Moore, a consultant to this project, carried out the challenging task of writing the report while ensuring that the information and analysis provided by all the research partners are accurately reflected.

Finally, we would like to thank the United Nations Development Program (UNDP) without whose support this project would not have been possible.

Mekong Migration Network

April 2015
Introduction

What do migrant women do before they go to doctors? For many, formal health care facilities are a last resort. While most reports on health in the Greater Mekong Subregion (GMS) focus on access to that limited, last resort option, this study looks both at migrant women's access to health care and also includes details of what happens before that.

This research project focuses on how women take care of their own health, what prevention measures and self-treatment measures they take, and how they make decisions about when to self-treat, to seek advice from a pharmacy, or to see a doctor. This study looked at factors that affect their ability to look after their health – whether through self-care or formal health care. And it offers robust suggestions on how governments, non-government organisations, and health care providers, including pharmacists, can improve migrant women's self-care and health care in the region.

The Mekong Migration Network (MMN) is a subregional network of civil society organisations and research institutes in the Greater Mekong Subregion (GMS). MMN has done previous work on HIV and health in migration. This study has a first focus on migrant women's self-care and asks three questions:

1) **How do migrant women take care of themselves?** In this MMN wanted to know what preventive measures and self-treatment measures migrant women use; and what options, including at pharmacies, are available to migrant women.

2) **What underlying factors affect migrant women's health rights?** MMN asked migrant women how migration has affected their health and ability to maintain it. Further, how do gender-related factors affect self-care and health care, both generally as well as specifically in relation to sexual and reproductive health rights?

3) **What policy enhances and hinders migrant women's ability to look after their own health?** MMN looked at what gaps and enabling factors exist in current policies, laws, health care regulations and mechanisms in the six GMS countries. The study asked migrant women what policy changes they recommend.

We sincerely hope that migrant women's voices are heard through this report. The conditions created by migration in the GMS increase a woman's risk of ill-health, while simultaneously limiting her access to both resources for self-care and formal health care treatment.

Governments in the GMS have an interest in ensuring migrant women are healthy. Healthy migrant women and their families contribute greatly to the economies of the region, and improved public health outcomes for all throughout the region are important. Above all, migrant women, like all people, have a right to health. Governments must ensure that migrant women have the means to look after their wellbeing in order to maintain healthy and productive lives.
Methodology, Participants and Scope

Women migrating across borders of the GMS participated in this research. 70 women were interviewed in destination countries. 44 women were interviewed in their countries of origin after they returned home. Women from all six GMS countries were interviewed. 59 percent of interviewees had some form of migration documents; 41 percent did not. A majority (62 percent) were not covered by any health care insurance.¹

Women interviewed worked in construction, agriculture, domestic work, sex work, retail, manufacturing, trade or in their own homes. Some were married, and some migrated for marriage. All were over the age of 18,² and 27 percent of the women interviewed had 5 or more dependents relying on them.³ The time they were or had been in the destination country ranged from less than a year to 60 years. Interviewees included:

- In Thailand, migrant women from Myanmar, Cambodia, and Lao PDR.
- In Myanmar, returnees from Thailand and China
- In China, migrant women from Myanmar and Vietnam
- In Vietnam, returnees from Cambodia
- In Cambodia, returnees from Thailand and migrants from Vietnam
- In Lao PDR, returnees from Thailand

Specific locations of where migrants came from and migrated to are in the following map.

¹ Health insurance rates of study respondents varied across countries. In Thailand 59 percent of respondents were not insured in any way. In Cambodia 100 percent were not insured. And in China 38 percent did not have any health coverage.
² The ages of most interviewees are mentioned when quoted. For those interviewed by Empower, all interviewees were between 25 and 45 years of age.
³ 63 percent of the dependents women were providing for were not their children or parents, but extended family.
Map of Research Participants’ Places of Origin and Destination

Locations where the migrant women interviewed for this report migrated to, and locations they originally migrated from, are marked in the map.
In all GMS countries key informants who knew information about migrant women’s access to health or their self-care were interviewed. Interviewees were identified by NGOs in Myanmar, Cambodia, China, and Thailand. Interviewees were selected by government officials in Vietnam, and by health centres in Lao PDR. This undoubtedly caused some bias in results, particularly around questions about where women received health information from – since many would have received it from the organisations who invited them to participate. We also had potential bias in our data from Lao PDR, where interviewees were interviewed only in an HIV clinic, but the interviews were conducted after the report had been drafted and too late for us to include their data in any statistics or numbers listed in this report. Therefore only two case studies from Lao migrant returnees are included in the sub-section on HIV/AIDS near the end of the report.

Migrant women were our main key informants, as we primarily wanted to know how they take care of themselves. But we did also interview doctors, other health care professionals, employers, NGO staff, and government officials in health ministries.

With respect to scope and limits in findings, it was hard to generalise across the region about some issues because the situations and experiences of migrants varied.

Some women migrated to very isolated fishing villages; some worked on Thai farms or urban construction sites; some were sex workers in China and Thailand; some dried fish on the outskirts of Phnom Penh in an isolated Vietnamese community there; some were domestic workers in Thailand; some were married to Chinese men living in rural areas. Some could access health systems. Some could not. Some made 80 USD per month, while others made 500 USD per month. Some had the resources to self-treat well. Some did not.

Further, some barriers to health faced by migrant women are also barriers that migrant men face, or that nationals/non-migrants face. The scope of this research did not allow for a comparative study with migrant men or with nationals. In fact, there is very little data on how often nationals use home and traditional

4 These 10 additional interviewees are not included in total number of participants listed for this study.
remedies or pharmacy available medicines before seeing doctors. We cite the little information we were able to find. More research is needed in this area not only for migrant women but for all people in the GMS.

MMN researchers felt that the issues that affect migrant men and nationals cannot go without mention, because some of them, such as difficult documentation processes or high costs, are high barriers for migrant women's health. Nonetheless, this report tries to highlight self-care practices, policies and other underlying factors that particularly relate to migrant women.

This study uniquely looked at migrant women's self-care in the region. Further research is needed to assess:

- the appropriateness of self-care practices and pharmaceutical care, on which migrant women rely;
- the kind of information that migrant women are specifically lacking for proper self-care; and
- how self-care and health care are different for migrant men and nationals in the GMS.

Research partners from all GMS countries (See Annex 1: Project Partners) first met in late November 2014 to finalise the research design, develop a standard questionnaire and plan research details together. The objectives of the research were agreed as the following:

- To provide empowering literature and perspectives on migrant women's health
- To learn from migrant women
- To provide evidence to reduce migrant women's vulnerability to health problems and HIV
- To inform projects and activities to strengthen what women migrants are already doing to take care of their health
- To strengthen the alliance of partners in the Mekong Migration Network
- To develop recommendations for policy reform and change in practice

Eight members of MMN, including six NGOs and two universities, conducted research in all six GMS countries (See Annex 1: Project Partners). The MMN secretariat as well as the country research partners conducted literature review and secondary background research. Research partners translated the questionnaire into GMS languages and conducted interviews with migrant women and other key informants from December 2014 to February 2015.

Research partners also agreed to abide by ethical principles related to full informed consent, confidentiality, and anonymity during the first consultation meeting. When reporting the interview results, the partners anonymised names of participants, unless participants specifically told them that they wished for their name to be included. Research partners collectively analysed data and findings at a second research consultation meeting in March 2015.

One group followed a different, and complementary, research method. Empower, a sex worker organisation in Thailand (See Annex 1: Project Partners), used participatory methods in a workshop, rather than interviews, to ask and discuss the research questions with sex workers. Individuals' answers were clarified, and group discussion led to the development of common priorities and recommendations.

Participants gave permission for the inclusion of their photographs and quotes in this report.

Please contact MMN with any questions on methodology or scope of the project.
Context Setting: Migration and Health in the GMS

Brief Background on Migration in the GMS

The GMS is a geo-economic area that was formed as a subregional bloc following the economic cooperation programme initiated by the Asian Development Bank in 1992. It includes Myanmar, Cambodia, Lao PDR, Thailand, Vietnam and the Yunnan and Guangxi provinces of China. The region is home to about 326 million people. People migrate within the region and outside of it looking for safety or a livelihood. Growing gaps in economic and political development between countries in the region, instability and ethnic conflicts, combined with porous national borders, have resulted in large numbers of people migrating to neighbouring countries.

Over the course of the past three decades, international migration in the GMS has taken place largely through informal channels. Thailand is the main destination country in the region, though migrants also move to Lao PDR, China and Cambodia. Of course people in GMS countries also move outside the GMS region. This report, however, focuses on intra-GMS cross-border migration.

For female migrants the migration process places them at a disadvantage in comparison to their male counterparts: many barriers prohibit women migrants from becoming documented workers, leaving them vulnerable to exploitation and sexual harassment in the workplace as well as in the communities they live in. It is extremely difficult for migrant women to obtain formal immigration status as they are predominantly employed in informal sectors, and many of the policies imposed by both countries of origin and destination exclude these sectors from legal migration channels and/or registration processes.
### Migration Numbers in GMS Destination Countries

THAILAND: Over 3 million migrants from Myanmar, Lao PDR, and Cambodia are in Thailand. About half are undocumented. About 80 percent are from Myanmar, and 10 percent each from Lao PDR and Cambodia. They work primarily in low-wage sectors such as agriculture, construction, fisheries and seafood processing, the entertainment industry, garment factories and domestic work.

LAO PDR: There are approximately 200,000 migrant workers in Lao PDR mostly employed in the construction sector, where Vietnamese and Chinese investors and contractors prefer to employ their compatriots given their skills, ease of communication, and willingness to work for low salaries.

CHINA: There are about 40,000 Burmese and 32,000 Vietnamese in China, according to government estimates. In Yunnan Province (part of the GMS), there are about 47,000 migrants total, 35,000 of whom are Burmese living in Ruili City. As a result of restrictions on the numbers of children that women are allowed to have, there are unequal numbers of men and women in China, and women from Vietnam and Myanmar move to China for marriage.

CAMBODIA: Over 100,000 Vietnamese live in Cambodia. Estimates greatly vary with some reports citing the number as many as 750,000. Some live just into Cambodia at the borders, working as traders. Others move to fishing villages on the Tonle Sap River or to big cities like Phnom Penh.

MYANMAR: Chinese investment has lead to companies taking Chinese labourers to work in Myanmar. This study did not have the scope to cover this group.

---


Overview on Health Issues in GMS Countries

Inflexible health care systems in the GMS exclude people who are not living in their hometown, who do not have documentation, or who have not contributed to a health scheme (See Policies on Migrant Health Care in the GMS section). Due to these exclusions and other factors, migrant women often lack *de facto* access to health care. Migrant women usually treat themselves and continue going to work during illness. Our research findings speak clearly to this.

Health of women across the GMS varies widely. Antenatal coverage in the region ranges from 35 percent in Lao PDR to 99 percent in Thailand. Maternal mortality ratios for Myanmar, Cambodia, and Lao PDR are 200, 250, and 470 per 100,000 live births, respectively, compared with the Southeast Asia region's average of 150.

Spending on health care in Myanmar is just 2 percent of GDP (about 28 USD per person), with 5 physicians per 10,000 people. Lao PDR is not dissimilar with 2.8 percent of GDP spent on health care and only a stark 1.9 physicians per 10,000 people. Migrants are leaving these countries primarily for Thailand where figures are not drastically different at 4.1 percent of GDP dedicated to health care and 3 physicians per 10,000 people. As this report shows, migrant women who arrive in Thailand have a lot of difficulty accessing those 3 doctors per 10,000 people.

GMS countries' health systems require that people using them pay a percentage directly out-of-pocket for their health care. In Myanmar, health care users shoulder 80 percent of the bill, while in Thailand users only pay 14 percent of their health costs themselves. In Vietnam people pay 56 percent out-of-pocket, and in China they pay 35 percent. Migrants often pay out much more than nationals for health care. In Cambodia for instance hospitals often charge foreigners double.

---

Vietnamese migrant woman in her 50s with no occupation, Svey Pak community, Phnom Penh, Cambodia (Photo credit: LSCW)

12 Greater Mekong Health Security Partnership.
14 Ibid.
How Migrant Women Take Care of Their Health Without Doctors

What do migrant women do before they go to doctors? For many, formal health care facilities are a last resort. While all undocumented workers face similar hardships, it is particularly challenging for women who bear increased burdens and discrimination because of their gender: lower pay and thus financial limitations; work in informal sectors and thus undocumented status; lower levels of education/literacy and thus less access to health information; and patriarchal gender norms and thus less negotiating power and fewer health rights at home, in hospitals, and at work. Most migrant women in the GMS lose their jobs when pregnant, with no recourse to justice or remedy.

Health care is costly and takes time that many migrant women do not have. When they arrive at hospitals, they face discrimination or language barriers (See Underlying Factors that Aff ect Migrant Women's Access to Doctors and Hospitals section), so most prefer home or traditional remedies or pharmacy-available medicine and/or advice, over care at public hospitals. Later sections of this report do look at access to public health care, but first a look at the under-researched areas that deserve more of policy makers' and other stakeholders' attention, because migrant women are taking care of their health as best they can without doctors first.

What is Self-Care? A health resource for migrant women

Self-care is the care a person provides herself.

A migrant woman's ability to take care of her health without doctors is dependent on the resources she has available in migration – information, money, medicines/herbs/materials for treatment, and time.

"Whatever happens to us, we have to look after ourselves... no one else helps us... sex workers are always helping ourselves and looking after others, too!"

Chinese migrant working as a sex worker in Thailand

"There was no one I could seek out for help or rely on if I got sick, so I took good care of myself." Burmese returnee in her 20s who worked as a domestic worker in Thailand

Self-care includes both prevention and treatment. And, an important part of self-care is the knowledge of one's limits – i.e. when to seek others' help. Migrant women's self-care knowledge and skills are culture and situation specific.

Sometimes migrant women do not have the luxury of being able to care for their health – because they do not have the resources (time, money, information, remedies) to do so and/or because the health of someone else in their family is prioritised.
Continuum of Care

In the GMS, migrant women’s continuum of care typically starts with prevention, then self-treatment using home remedies, then moves to pharmaceutical medication and/or advice, and finally to doctors at health care facilities if women have access to them and do not feel barred due to discrimination, language barriers, costs, fear of deportation, and many other factors detailed in this report. Sometimes women visit places of worship in order to meditate, pray, or seek help. Self-care is an important health resource in the continuum. So are pharmacies. These two sites of care get very little attention from policy makers.

MIGRANT WOMEN’S TYPICAL CONTINUUM OF CARE IN THE GMS

```
<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>SELF-TREATMENT</th>
<th>PHARMACEUTICAL MEDICATION and/or ADVICE</th>
<th>DOCTOR at health care facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACE OF WORSHIP</td>
<td>home or traditional remedies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessed at any stage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

Core sites of migrant women’s health care
Sites lack stakeholder attention

Note: Migrant women do not have de facto access to all sites of care in all GMS countries. Treatment migrant women receive at each site (including at health care facilities) may or may not be appropriate. Traditional healers also provide some health care to migrant women, but were not studied in depth or mentioned very often by migrant women.

Prevention

Self-care begins with prevention. For many, getting sick is not an option. When asked how they avoid disease, women MMN interviewed said they use a mosquito net, practice safe sex, avoid blood and ensure only one use of blades and syringes (to prevent HIV), and wear a mask when near people with respiratory infections. At work women in agriculture said they use masks, aprons, glasses, and shoe covers to avoid pesticide induced sickness. Several domestic workers reported that they try to “stay in the house so [they do not] get sick outside.” Sex workers highlighted various ways of avoiding drink quotas set by employers (the minimum number of drinks they have to sell each night before they can finish work) and enforcing condom use as major protections.

“I diagnose myself if it is not serious and sometimes get medication from the pharmacy. If I feel worse I will talk to the NGO clinic.” Vietnamese migrant in her 20s working as a rubbish collector in Cambodia

“I wear gloves to prevent cuts, but when I get cut, I just wash or use plasters.” Vietnamese migrant in her 30s working part time in seafood preparation in Cambodia
Migrant women generally rely on home or traditional remedies as a first resort. This includes simple home remedies like hot ginger tea or even just rest, which many women said is what they try first. This also includes herbal remedies, eating certain types of food to relieve specific symptoms, massage, scraping, meditation and amulets.

“**We have to be smart to be healthy at work here. Older workers share tips like ways to avoid drink quotas....**”
Burmese migrant working as a sex worker in Thailand

“I have good living conditions and food which helps me stay healthy.” Cambodian returnee in her 20s who worked as a domestic worker in Thailand

“To avoid illness, I drank a type of remedy called Tieu ban lo, and I bathed with fig tree leaves and water from boiled acacia. They are remedies from Vietnam.”
Vietnamese returnee in her 50s who was a trader in Cambodia

---

**Home and Traditional Remedies**

“I was worried about money, so I didn’t go to the clinic or hospitals, and just took traditional medicines.”
Burmese returnee in her 30s who worked in a garment factory in Thailand

Migrant women generally rely on home or traditional remedies as a first resort. This includes simple home remedies like hot ginger tea or even just rest, which many women said is what they try first. This also includes herbal remedies, eating certain types of food to relieve specific symptoms, massage, scraping, meditation and amulets.

“My fingers feel numb while planting flowers, so I try to cure the problem using a traditional Shan method where I cover my head with a blanket while breathing steam from medicine.”
Burmese migrant in her 30s working in agriculture in Thailand

---

15 Several Vietnamese interviewees talked about “leaning wind”, which is known to English speakers as scraping. It is a traditional Chinese medical treatment “gua sha” in which the skin is scraped to produce light bruising. Practitioners say it releases unhealthy elements from injured areas and stimulates blood flow and healing.
When asked if they could find the same remedies they used at home, 66 percent of migrant women said they could. Further, 56 percent of interviewees said they were able to find better or alternative treatments in the destination country. Burmese women who do not find it easy to find remedies in the destination country said they carry those remedies with them when they migrate. Vietnamese women just over the border in Cambodia look in the forest for the same herbs they harvest for treatment at home.

One woman said “I think I am healthier at home because I can get traditional medicine whenever I get sick.” When asked what they could not find, Burmese returnees said they could not find lotus leaves for coughing or bronchitis, or herbs to treat diarrhoea and skin disease. Vietnamese migrating to Cambodia were one group that said they could find herbs easily. Other women in the study talked about not knowing the names of remedies when they were in the destination country. Some women said they could find different herbs. One woman mentioned finding Thai herbal medicine for menstrual cramps and after giving birth.

Nonetheless, in order to be able to find and use medicines they already have knowledge about, migrant women need information on equivalents of traditional remedies in their languages. Furthermore, health practitioners and pharmacists who sometimes dispense herbal or traditional remedies need to play a role in providing appropriate information about them. A 2010 study in Thailand found that herbal medicines did not always specify ingredients, indications or precautions.

---

Traditional medicine knowledge and skills are disappearing very fast. We leave home when we are young, and we are the second or third generation to do this, so what plants and medicines to use is no longer passed on.”

Burmese migrant working as a sex worker in Thailand

Pharmacies

The majority of interviewees relied heavily on pharmacies for medicines. Throughout the GMS medicines are available in pharmacies without prescriptions – making access to medicine possible without seeing a doctor. Many migrant women have extremely limited access to doctors, so they report appreciation for this easy access to drugs. In the best cases, pharmaceutical advice is responsible, regulated, and language accessible for migrant women. Migrant women access drugs faster, cheaper and without the discrimination that they might find in hospitals. In Thailand where doctors in hospitals directly report migrants’ health status to immigration authorities (see Policy section), migrant women can rest assured that pharmacists are not connected to immigration officials.

Yet, counterfeit or poor quality drugs, overuse of antibiotics, and poisoning are risks of self-treatment in a region that does not strictly regulate pharmacies or require prescriptions for most drugs. Pharmacists are not always present when drugs are dispensed, and sometimes migrants receive no advice. Studies in the region have shown that pharmacists and pharmacy personnel do not always dispense drugs appropriately. Because of language barriers/miscommunication or lack of training, the wrong medicine can also be dispensed, resulting in improper treatment, women’s money misspent, and further sickness. Other studies indicate that pharmacists rarely ask women if they are pregnant or breastfeeding before selling drugs to them, an omission that could harm their child. Regulation of pharmacies and enforcement of that is greatly needed in the region to ensure that medicines are dispensed responsibly.

“I bought medicines [from grocery boats].” Vietnamese returnee in her 50s who worked as a fisher in Cambodia

“I just bought medicine for a temporary cure because there were no hospitals there.” Vietnamese returnee in her 30s who worked as a beverage vendor on the boat in Cambodia

“I bought medicines for headache and skin infections at the pharmacy and the salesperson explained how to take and use the medicines.” Burmese returnee in her 30s who worked as a domestic worker, a waitress at a restaurant, a factory worker and a salesperson in Thailand

20 Boonyaprapa, S., M.Sc., B.Pharm, “Self-care in Pregnancy and Breastfeeding: Views of women and community pharmacists in Thailand”, Thesis submitted to the University of Nottingham, School of Pharmacy, for the degree of Doctor of Philosophy, October 2010. See references in the study to similar pharmacy practices in countries outside the GMS.
This report discusses in detail later the barriers that keep migrant women from moving further along the continuum of care past pharmacies and to doctors. Needless to say, for many, this is as far along the continuum as they can go. In this study, sex workers in Thailand particularly discussed the fact that they much prefer the ease, efficiency and time-saving that they get from using pharmacies.

Undocumented migrant women in the study reported multiple barriers to accessing even advice from pharmacists. In addition to language barriers, many undocumented women in the region fear moving outside their workplace or home, as they risk arrest. In this study, women without documents in Cambodia reported developing their own mechanisms to access pharmaceutical medicines and advice via friends and co-workers; other migrants who were documented and able to speak the local language would purchase medication on their behalf.

If stakeholders in the GMS want to improve migrant women’s health, pharmacies are an important place to focus attention. Pharmacists can provide information not just about specific medicines but also about preventive care and about when to see a doctor. Pharmacists Associations for instance can play a large part in ensuring proper training, language accessibility (at a minimum with written translations of information on common medicines), and non-discrimination. Over a decade ago a couple of organisations in the region worked with pharmacists to boost their ability to give proper information about and diagnose tuberculosis, as well as when to seek medical attention.21 More of this and other kinds of training and programming should be done. A recent study of Thai women relying on pharmacists in Thailand during pregnancy and breastfeeding found that “some pharmacists still lacked the confidence to provide appropriate advice for these women and appeared to need more support with up-to-date information... In addition, continuing education and up-to-date information [would] help to increase the pharmacists’ confidence in providing appropriate advice to pregnant and breastfeeding women.”22

Places of Worship

Our study did not start out asking about spiritual elements of self-care, and more research is needed on this. Nonetheless, women did talk about going to places of worship or seeking out counselling from monks as part of their search for health. Women in Thailand said they would go to a temple if they could not get pregnant, if they had “bad feelings”, if they had just had an abortion, been raped or experienced other violence. Sometimes they participate in special religious ceremonies, and at other times, they become a nun for a couple of weeks. One Burmese participant said she felt like she could take care of her health much better at home because she had access to religious practices that she did not have in the destination country:

“I am healthier at home because I can freely practice my religion. I can eat vegetarian. My father heals my health problems with his spiritual power. I have to eat vegetarian, and do meditation and other religious practices.” Burmese returnee in her 50s who worked in agriculture in Thailand

---

Decisions Women Make: Choosing among options on the health care continuum

54 percent of respondents had been to a hospital or clinic for health care. For a minor ailment, 31 percent of women said they would use self-care (not including visiting a pharmacy), 49 percent would visit a pharmacy, and 16 percent would see a doctor. There are many factors that go into this decision making, but, as NGO respondents in Cambodia observed, migrant women tend to only seek medical advice or care when they consider their condition to be serious.

Research partners asked migrant women about what mattered most when they chose a health care option. 83 percent of women said “effectiveness” was “very important”. As second tier priorities in decision making, 54 percent of women across the GMS said “cost” was “very important”, and 53 percent said “safety” and “confidentiality” were “very important”. As a third tier of priorities, 40 percent of women chose “friendly service”, and 37 percent chose “ease” as “very important”.

Sex worker respondents in MMN’s study were clear in saying that “time/fast treatment”, followed by “effectiveness”, are the biggest considerations they have when deciding among options. “Confidentiality” was prioritised last, and when queried in a focus group, sex worker participants said that they had no expectation of confidentiality.

Different groups have different beliefs about health, which impact their health seeking-behaviour. For instance, the Karen people tend to place trust in spirit healers, but Burmese and Mon peoples prefer accessing the Thai health service. Some go to hospitals and use health services only when it is necessary and when they have a severe disease, such as malaria.23 Similarly, financial resources also impact choices. We know from other studies, such as one in Vietnam, that the poor tend to use self-treatment, as defined in the study, more frequently than wealthier people (31 percent vs. 14.5 percent of illness episodes respectively).24 Information from a health expert in the Southeast Asia region suggests that 40-50 percent of people rely on home and pharmacy treatments before going to see a doctor.25 As this study did not have counterfactual data of self-treatment rates of nationals living the same areas as migrants, the study is unable to conclusively speak to how rates of self-treatment among migrant women compare to nationals, or indeed to migrant men. The identification of significant barriers that are higher for migrant women suggests, however, that migrant women most likely have higher rates of self-treatment than nationals.

“I would use doctors only when I couldn’t cure myself with rest and medication from my employer.”
Cambodian returnee in her 20s who worked as a domestic worker in Thailand


24 Note that there is not a standard definition of self-treatment and it may or may not include pharmacy-available medication, which may or may not been given under advice of a pharmacist. See T. B. T. Nguyen et. al. (2008) “Choice of healthcare provider following reform in Vietnam”, BMC Health Services Research, available at: http://www.biomedcentral.com/1472-6963/8/162.

25 Email correspondence, anonymous researcher on health issues in Southeast Asia.
Quality of Health Care: Effectiveness and scope

“As above, “effectiveness” is migrant women’s top consideration in making a choice of what kind of health care to seek out. Migrant women in Thailand and China thought that the quality of practitioners and medicine in those destination countries was good.

Women in Cambodia, however, did not receive good quality care when they sought out doctors, and thus they tended not to do so. Quality of medication and knowledge of medical staff were identified as substandard by both interviewees and other key informants.”

“In my country, there are inadequate facilities and medicines; moreover, you could not get treatment if you do not have money. Here, they have everything.” Burmese migrant in her 20s working in agriculture in Thailand

“The quality of health care services in Cambodia is not good but is so expensive. For example, my sister was diabetic. When she was tested in Cambodia, she was diagnosed as “not serious”. After that, she came back to Vietnam for treatment. But she was in the final stages of her life, and she died.” Vietnamese returnee in her 50s who worked selling fish in Cambodia

“Because of the high costs of treatment, we do not use health care services in Cambodia. We cannot afford to go to Nam Vang [the Vietnamese name for Phnom Penh] for health treatment, and doctors are not qualified. For example, I have kidney stones, but they diagnosed a backache.” Vietnamese returnee in her 30s who worked as a beverage vendor on a boat in Cambodia

“My youngest daughter died of hemorrhagic fever. She got sick at aged 6 and had been treated for a while in Cambodia before her treatment in Tay Ninh, Vietnam. When her temperature was high, we asked a Cambodian doctor to treat her. I asked him whether it was possible to treat her fever, and he said yes. But suddenly, at 3 pm my daughter got worse, and she could not recognise anything. We had to drive her back to Vietnam. But Vietnamese doctors said that they could not do anything because the illness was too serious. The Cambodian doctor also did everything, but it did not work.” Vietnamese returnee in her 60s who was a trader in Cambodia

Mental Health Services Unavailable

A section at the end of this report details availability of sexual and reproductive health services, but a special mention must be made here about the low recognition of mental health issues in the region, and limited services available for those who recognise issues. Services are even more limited for migrant women, who find it hard to access one stop crisis centres for victims of sexual violence for instance. A 2015 study shows
that just under 70 percent of migrants in the GMS suffer some form of mental health problem, such as depression, anxiety and Post-Traumatic Stress Disorder (PTSD).26

"While living on a boat on Tonle Sap Lake, I often got headaches and suffered from loss of sleep. I guess that it originated from worry and anxiety because we all always worried about risks such as being chased by local authorities, robbed by gangs, etc. After I returned home, I have not faced anymore headaches or sleep disorders." Vietnamese returnee in her 50s who worked as a fisher in Cambodia

Sex workers, who participated in the workshop organised by MMN-partner Empower for this study, discussed that they do not know of any places they could go for mental health care in Thailand. MMN study respondents talked about self-care for mental health. For sleep problems, migrant women said they treat themselves, meditate, or drink cough medicine. For depression, several women mentioned talking to family as a way to alleviate it. When homesick, they would call home if possible or simply miss home and have to keep working. For drug addiction or alcoholism, respondents said they did not know what to do.

**Women Prioritise Health of the Breadwinner – Whether themselves or others**

Women worry about the health of the breadwinner in their household. MMN asked women whose health was prioritised. Women prioritised their own health when they were the breadwinner providing for dependents. When their husband made more money, his health became the focus.

"My health is important as I am the main income provider for my whole family." Burmese migrant in her 50s working as a salesperson in Thailand

"I am the backbone of my family so I need to keep strong and healthy. If I fall down, we all fall down."
Lao migrant working as a sex worker in Thailand

"My health is important because I have to support myself and my child." Burmese migrant in her 20s working in agriculture in Thailand

"Both of us need to be healthy because we both are breadwinners."
Burmese migrant in her 20s working in agriculture in Thailand

---

"The health of my husband is the most important thing because he can earn good money only when he is well. I cannot do heavy work like he does." Vietnamese returnee in her 50s with five children who worked in a fish market in Cambodia

A minority of women talked about the importance of their children's health.

"My daughter's health is most important because she is studying." Burmese migrant in her 40s working in agriculture in Thailand

Leaving Problems Untreated or Returning Home for Treatment

Some interviewees clearly stated that their health was not important. For some this was because the health of others needed to be prioritised. For others, it was because they did not have the resources to self-treat (See Underlying Factors that Affect Women's Self-Care section) or access to health care. Some women (as in the quotes) need to prioritise sending remittances home.27 A report on migrant women's self-care in another region notes health concerns are often trumped by "more immediate survival needs (income, housing, support of other family members, etc.)."28

Some health care providers we interviewed were frustrated that women had not done more to prevent disease before they came to their offices. While this is understandable from a practitioner's perspective, as this report details later on, many women cannot afford the luxuries of basic self-care that disease prevention requires, whether because their living conditions promote ill-health (See Living and Working Conditions section) or because immediate survival needs come first. As a migrant woman in a study on free breast cancer screening services in another region notes "I have no time for potential troubles," i.e. even when specialised preventive services are available to women, they would not be able to treat the condition if it was identified, so they feel like there is no need to avail themselves of early detection schemes.29

---


29 Ibid.
Several women mentioned in interviews that they waited until they returned home to treat illness, because they felt health care was better in their home country or because the barriers to access it in the destination area were too high. For some conditions, like mental health problems, there was simply no treatment available even if women did have health insurance in destination countries (See Mental Health Services Unavailable section). Some returnees interviewed in Cambodia said they had come home specifically to recover from an illness before re-migrating.

In one case, an interviewee told MMN researchers about a friend who had died in childbirth. Though she and an untrained midwife knew there were complications during the birth, the hospital was far, and the pregnant mother and her relatives faced language barriers. Because they could not speak Khmer, they were afraid and worried about misunderstandings between them and hospital doctors and nurses. Therefore they decided to wait and not go to the hospital. While most of the respondents who did not treat or who delayed treatment did not suffer major consequences from doing so, non-treatment is a risk. Barriers to treatment urgently need to be reduced throughout the GMS.

“I got an infection in Thailand but didn’t treat it until I returned home.” Cambodian returnee in her 30s who was a construction worker in Thailand

“I usually came back to treat illness in hospitals in Vietnam.” Vietnamese returnee from border area of Cambodia in her 50s who worked as an ice retailer in Cambodia

Many Burmese migrant women give birth at the Mae Tao Clinic in Mae Sot, Thailand, where they find it easier to communicate in Burmese with the clinic staff (Photo credit: Mae Tao Clinic)
Young and Healthy Migrant Women

“When I was in Cambodia, I was young so my health was very good.” Vietnamese returnee in her 30s who worked as a beverage/food vendor in Cambodia

While some people, as in the previous section, are simply unable to treat illnesses, others never fall ill and do not have to worry about health while abroad. It is well recognised that globally young and healthy people feel like they do not need to be concerned about health. The same is true of young, healthy migrant women in the GMS. When asked what health problems they encountered in migration, many said: “None, I was healthy.” When researchers asked another woman where she got health information from, she said: “No one as I was healthy and I didn’t understand that I should have health knowledge.”

The ramifications of this are that, for instance, most migrants that MAP Foundation works with do not see the need for a Social Security or Compulsory Migrant Health Insurance card. The insurances are costly relative to their wages; they see themselves as healthy with low risk of illness; and the cards tie them to care in one single (and often inconvenient) hospital (See Policies on Migrant Health Care in the GMS section). People tend to move when they are young and healthy, and migrants often underutilise health services.30

A Burmese migrant woman in her 20s working at a factory in Mae Sot, Thailand (Photo credit: MAP Foundation)

Underlying Factors that Affect Migrant Women’s Self-Care

Many factors affect migrant women’s ability to self care. Living and working conditions affect their ability to prevent disease. In terms of self-treatment, women need resources. They need resources of information, money, remedies and time. Without those, migrant women struggle to treat their illness without doctors.

Once they are in destination countries, women often face poverty due to their precarious legal, social and/or economic situations and are deprived of the most essential resources necessary to maintain good health.

NGO informants in Cambodia particularly noted that “even when [Vietnamese women living in a slum area] are aware of how to keep themselves healthy, they may lack the capacity to achieve this. This is apparent in unhygienic and poor living conditions, in addition to women working long hours in physically demanding jobs.”

This section focuses on factors affecting self-care without doctors. The next section focuses on factors that affect women’s ability to access formal health care.

Living and Working Conditions

Women make the best decisions they possibly can for better and healthier conditions, but sometimes they have to live or work in unhealthy places. Migrant women’s ability to prevent illness and injury is heavily dependent on their surroundings.

When women are lucky, living and working conditions in migration are good. Women working in a factory in China told MMN they valued the chance to work in that particular factory because the management was very “humane”, offering mosquito coils to them as well as distributing medicines to prevent epidemic diseases in different seasons. Although worried about infection with HIV/AIDS, one Burmese woman in China said the life there is better than in Myanmar because there is enough food and living conditions are better. She said: “We drink mineral water here, but in Myanmar, we can only drink water from a pool or river.” Another person talked about the physical activity in her work being good for her health.

“I think I am healthier working in my country because the work here is so hard and tiring.” Burmese migrant in her teens working in construction in Thailand

“I have a hard time breathing because of smelling the chemicals. My hands become swollen, and rashes appear on my skin.” Burmese migrant in her 20s working in agriculture in Thailand

“I felt at ease as I was physically active while working, which was good for my health.” Burmese returnee in her 20s who worked in a soft drink factory in Thailand

On the other hand, conditions are more commonly less conducive to good health or preventive care. When asked what work-related ailments women faced, they described skin problems, repetitive motion injuries from factory work, accidents, stress/nerves from long arduous work, and chemical exposure affecting reproductive health, their skin, and their nervous system. Sex workers described requirements to drink alcohol and employer pressure to use addictive drugs to stay awake.
MMN’s previous studies have shown that a large range of working conditions can have negative impacts on reproductive health. Stress, rotating shifts, and exposure to solvents can cause menstrual problems which in turn affect ovulation. Exposure to radiation and some chemicals can damage eggs and sperm causing miscarriages and birth defects, while other substances may cause reproductive and other cancers. In addition, long working hours during late pregnancy can increase the risk of pre-term delivery and low birth weight babies.31

Migrant workers in the GMS often live and work in the same place.32 The inability to leave construction sites or factories, for instance, can mean 24-hour exposure to airborne particulate or chemicals. Sites are often crowded and sanitation insufficient. Water can be contaminated by chemical substances on site.

---


For women and girls, poor toilet facilities make management of menstruation difficult and contribute to the risk of infections.\textsuperscript{33} Low quality water also causes numerous other diseases.\textsuperscript{34}

Sex workers sometimes also live in their workplace, where customers smoke and ventilation is often weak. Sex workers in the region reported stress from long hours as well as the need to drink alcohol at work. Sex workers in Thailand also reported struggling with addiction to stimulants, used to help them stay awake at night and work long hours. Sometimes employers put the stimulants in their drinks, or sold the drugs to them.

\textsuperscript{33} Action for Sexual and Reproductive Health Rights, p. 43.

Information on Health

“One can ask others about health information. I can get information about the organisations that are working on health issues. Through my friend, I know more about health rights.” Burmese returnee in her 40s who worked as a sex worker in Thailand

“One I get better information about health than at home.”
Burmese migrant in her 20s working as a domestic worker in Thailand

“I have received more information about health on the Thai side than back home, but I still get inaccurate information.” Burmese migrant in Thailand

One of the most important resources women need to be able to take care of themselves is information on how to do so, what risks exist, and how to avoid them. Women are asking for information from friends, family and employers. Women ask work colleagues, often those who are older or who have been in a destination country longer. A few of our respondents knew that the information they received from these channels was not always accurate, however. Women receive some information from NGO pamphlets, radio shows, or workshops, but there remains a lack of information for migrant women.
Partly a lack of information on health is related to women’s lack of access to health care. Migrant women in Thailand fear going to gynaecologists and antenatal clinics for instance (See Pregnancy and Birth section). Because very few receive antenatal clinic care, they do not receive proper information and guidance related to health in pregnancy.

Findings showed that, in addition to whether their work site was isolated, women’s migration location made a lot of difference to their access to information. Vietnamese migrants who lived on the Cambodia border and were able to move back and forth more often had much more access to information. They heard information from friends and family when they went home, and they brought it back to Cambodia. By contrast women further into Cambodia, who were not living in border areas and not able to go back home with any frequency, had extremely limited information channels. They could not speak Khmer, and there was no Vietnamese language media. Neighbours were their chief source of information.

In some situations a person’s employer facilitated information sharing. For instance some interviewees worked in a factory in China that cooperated with local NGOs to hold health lectures and trainings for the workers.

Often however there is no information. As one example, a Cambodian woman migrated to Thailand as a construction worker and recalled being offered no information about work-related health risks or how to avoid them. After a few weeks on site, the woman purchased a pair of gloves for herself due to damage to her skin.

Migrant women across the region are at a disadvantage in accessing information. Many had less access to education during their youth than their male counterparts and thus have lower literacy rates. For instance, Buddhist temples in Myanmar have tended to prioritise educating men over women. NGOs in Chiang Mai, Thailand, have set up migrant language schools to teach basic literacy as well as the destination country language. However, because women (vs men) are expected to do housework on top of their paid work, they have no time to attend the language schools. Gender norms and discrimination play a large part in restricting their access to health and other information. In addition, sex education at schools in countries of origin is low or non-existent. In Vietnam only 0.3 percent of high schools teach sex education.35


“We don’t get information because we don’t go out, and we don’t know anybody.”
Burmese returnee in her 40s who worked as a domestic worker in Thailand

“Honestly, when I was working at Mae Sot as a sex worker, I did not know about HIV. I did not know that a condom can prevent HIV, STIs and pregnancy. I saw some of the customers using it. At that time I thought they were using condoms for their pleasure.”
Burmese returnee in her 40s who worked as a sex worker in Thailand
A Vietnamese returnee from Cambodia spoke of the implications that a lack of information about health care options had on her and her family. She had lived on a boat with her husband and children while in Cambodia, and she earned money by fishing and trading on the boat. She said:

“During the time in Cambodia, I did not know anything. Everyone living there had 9 to 10 children. After my fifth child, I heard news on TV and from my neighbours about contraceptive IUDs. I asked a doctor to row his boat to my house to insert an IUD in 2011. In 2012 I returned to Vietnam, and my IUD fell out when I worked in the field. I only knew I had become pregnant when the fetus was in the second or third month. Now my youngest child is seven months old, and I have been sterilised.”

Pre-Departure Trainings

If women’s migration is facilitated by formal and registered recruitment agencies in the region, some of these are required to give pre-departure trainings. The trainings are critiqued for being offered too late in the departure process and for being too brief in duration. They are regularly surface-level trainings that do not adequately cover topics of migrants’ rights; health risks in destination countries; health risks related to specific occupations; health insurance options at the destination; or where to find health information and care.

Some governments specifically require these trainings to include health topics, and often particularly on HIV (See Policies on Migrant Health Care in the GMS section for requirements per country where relevant). For example, in Lao PDR, the Ministry of Labour and Social Welfare has approved a pre-departure orientation regulation that mandates labour export companies provide HIV and AIDS education. Despite this, some reports reveal that programs are not always appropriate and that women migrants’ knowledge remains low post-training.

Time

Some respondents spoke about the lack of time for self-care. Migrant women often work long hours and are socially expected to do the majority of the housework and childrearing after work. There is little time for themselves. In addition, beyond setting long working hours, employers often restrict time by not giving women time during working hours to go to pharmacies, or by not giving them sick leave. Of the migrant women we interviewed, 35 percent did not get any form of sick leave. And for those that did, only 21 percent received a salary or partial salary during that time. It is not uncommon for domestic workers to work 7 days a week without a day off. In a 2012/13 survey, migrant domestic workers who reported having a day off varied between locations: 29 percent of the women surveyed in Mae Sot, which is adjacent to the border, did not have a day off per week. In Ranong, also at the border but on the ocean, 23 percent of migrant women did not have a day off, and Samut Sakhon, an industrial centre for seafood processing, had the lowest percentage of no days off at 8.5 percent.

56 With or Without Borders, p. B.
57 Ibid.
Many Burmese migrant women seek treatment at Mae Tao Clinic due to long waiting times at the Thai public hospitals (Photo credit: Mae Tao Clinic)

“I did not have enough time to take care of myself because I had to do business and bring up my children at the same time, so I disregarded my sickness.”
Vietnamese returnee in her 40s who worked as a food vendor in Cambodia

“I didn’t have time to take a rest, and even when I had menopause, I couldn’t take care of myself properly.”
Burmese returnee in her 50s who worked as a cook at factory in Thailand

“I would ask my friends to buy medicine for me and continue to work, since my employer would deduct from my salary if I took time off.”
Burmese returnee in her 30s who worked in factory in Thailand
Money

“Money is the best insurance when you get sick. I can take good care of myself in China because what I earn here is much better than in Burma.” Burmese migrant in her 30s married to a Chinese man in rural area in Yunnan, China

“In Thailand, one day’s wage can feed me for 3 days, so if I work regularly, I can save money and buy medicine. I do not have enough to buy medicine with my daily wage in my own country.” Burmese migrant in her 20s working in agriculture in Thailand

Many women move to find work. They hope they will find better paid work than at home. Money is needed for women to buy basic preventive care items and self-treatment remedies. Sometimes women, as in the quote above, do earn enough to take care of their health well. Sometimes they do not.

“Medication is better in Thailand, but it is too expensive for me.”
Cambodian returnee in her teens who worked as a rubbish collector in Thailand

Women’s wages are lower than male wages across all sectors in many countries of the Asia Pacific region. Women earn between 54-90 percent of what men earn depending on country and sector.\(^40\) This happens not only because women are concentrated in lower paid occupations, but also because they are paid less for similar or comparable jobs.

In Thailand, the national minimum wage is now 300 Baht (10 USD) per day. Before 2013, minimum wage was pro-rated according to the cost of living of each province. In reality, migrant workers generally do not receive the 300 Baht minimum wage. Depending on the type of work and the arrangement with the employer, wages can be well below this rate. There are also migrants who make more than minimum wage, but many cannot do so within a regular eight-hour work day or with any days off. Domestic workers are paid monthly, but may not receive their wages every month. One way employers avoid paying the minimum wage is through paying piece rate.\(^41\) Women working in the seafood industry peeling shrimp can make up to 400 Baht (13 USD) or more a day. They may, however, have to sit hunched over a pile of shrimp until it is all gone, regardless of how many hours it takes. The average monthly wage of migrant women in Thailand (as reported from a study done in 2012/13 prior to the new minimum wage) was 4,315 Baht (132 USD). Yet, around 20 percent of the women reported regularly sending money back home.\(^42\) In our study many women reported that a lot of their money goes to dependents, remittances or migration broker’s fees. There is not much or any left to spend on their health.

---


\(^41\) MAP Foundation and Clean Clothes Campaign (2014) “Migrant Workers in Thailand’s Garment Factories”.

“I had to send money back home to support my children’s education. My weekly budget was 500 Baht (16 USD) and even this amount I didn’t spend. I saved some of it, which meant I couldn’t buy food and eat properly.” Burmese returnee in her 40s who worked as a sex worker in Thailand

“I had to send back my savings to my family, and I didn’t have money in my hand. So, when I got sick, I never sought health care.” Burmese returnee in her 20s who worked as a sex worker in China

“I need to support my younger brother and his wife, so I don’t have enough money and I need to get a loan. So, when I get sick, I don’t have enough money.” Burmese migrant in her 30s who worked as a cleaner at a hospital in Thailand

“I support my mom and my husband’s parents. When I got sick, I felt distressed because I would have to spend extra money.” Burmese returnee in her 20s who worked in factory in Thailand

“Once I have sent money to my family and paid my bills it is very difficult for me to afford food and medicine.” Burmese returnee in her 30s who worked in construction in Thailand

When asked “What can improve the health of women?,” several Vietnamese interviewees prioritised money in their answers. Several people said that if they were wealthy, they would not have to work hard or worry about many things, which would result in health improvement.
Other Factors: Stress, diet, family support

Many interviewed women felt they had less stress, better diet and family support at home, rather than in destination countries. On the other hand, some felt that if they went home, particularly if they went home ill, they would be a stress on their family.

Vietnamese returnees from Cambodia said life is stable upon return, and they do not have to spend much time and energy to earn a living because their children have grown up and help support them now. Because of this, they said, their health is improved. Others said that if they have enough time to relax and they eat a good diet, their health will improve.

“My health in Vietnam is better. My life in Cambodia was very busy because I had to worry and think about many things. I had to bear much pressure there. It was not peaceful like in Vietnam. I did not sleep well at night because I had to worry about everything.” Vietnamese returnee in her 40s who worked as a food vendor in Cambodia

“In Vietnam, we can freely relax and do not have to worry much. In Cambodia, I had to spend much time earning money. To save money, I dared not eat very much. Because I spent too much energy at a hard job in Cambodia, I fell ill when I returned to Vietnam.” Vietnamese returnee in her 50s with five children who worked in a fish market in Cambodia

Some Vietnamese women in China offered a counter example. One described her life now as “jumping into heaven.” She described “a kind husband who treasures [her], two children, earning enough to feed [themselves], and constructing a family and home, which is [their] primary protection for health and significance of life.”
Underlying Factors that Affect Migrant Women’s Access to Doctors and Hospitals

“I didn’t want other people to know about my illness. It was difficult to arrange transportation. I didn’t have a day off. No one helped to take me to the hospital (due to language barriers).” Burmese returnee in her 40s who worked as a sex worker in Thailand

When women need to seek formal medical attention from a doctor, what barriers or enabling factors do they face?

Multiple factors intersect to restrict women’s access to formal health care. The previous section described factors affecting women’s preventive care and self-treatment. This section looks at factors affecting their ability to access formal health care. It looks at a wide variety of factors, but leaves legislation and policy for the subsequent section. The factors that migrant women talked about most affecting their access to health care are documentation, isolation, language, bureaucracy, time, cost, discrimination, and workplace policies.

Documentation

In the GMS it is harder for migrant women to travel with documents than it is for men. The jobs migrant women do tend to be ones that are not “formal” and therefore not eligible for “regular” migration schemes and the documentation for legal migration that come with them. Domestic workers from Cambodia moving to Thailand is one notable exception — the women-dominated domestic work sector is covered by a migrant export recruitment scheme, which provides documentation.

Often, however, burdensome requirements lead women to migrate through unofficial broker channels and work without documentation as it is easier, quicker and cheaper to travel informally. Without documentation, access to social security and health insurance is harder. See the Policies on Migrant Health Care in the GMS section below for exact details of regulations on documentation and eligibility for health care and insurance schemes. The below country cases give examples of how documentation relates to health care access across the region.

**Documentation Impacts Access to Health**

**CAMBODIA:** Lack of documentation leaves Vietnamese women migrants in Cambodia effectively with little to no access to services and treatment, except for those provided by NGOs. There are currently no protections in place for undocumented migrants and, as apparent in the Svay Pak community on the outskirts of Phnom Penh, women’s access to health care is highly reliant on NGO support.

**THAILAND:** Interviews with Cambodian migrant women returning from Thailand offer insight into two differing experiences of health services in Thailand. Generally women who migrated without documents had limited access to health care. Those with documentation experienced better health care and preferred it to services in Cambodia. As an example, most domestic workers migrated legally. They received health advice from their employer who even provided many interviewees with access to and payment for treatment at private clinics. This enabled the women to acquire quick and effective treatment when they had concerns about their health.
CHINA: Thanks to the efforts of local government, migrant women in Mengga Town can get certificates of marriage relatively easily. These certificates guarantee their status in Chinese families. When migrant women flee because of family violence, if they have the certificates of marriage, they can ask for help from the local women’s association or apply for a divorce. However, in another area, migrant women in Malipo cannot get certificates of marriage easily, and they remain undocumented. They take more risks in their marriages than women in Mengga. As one research organisation noted, “the only help for their life and health is to marry a good person.”

Arrest, Detention, Deportation

Whether rumoured or written into law, there is not clear separation between doctors in the GMS and immigration authorities. In Thailand the connection is explicit. A Thai health law (see Annex 2) specifically mandates that doctors send health examination records to immigration authorities with “Deportation” stamped in red ink on them if migrants “fail” certain aspects of the health exams which they have to take to qualify for documentation. Because of this explicit connection, migrants are rightly wary of going to see a doctor for fear of arrest, detention and deportation.43

“I was scared to go to the doctor because friends told me undocumented migrants are arrested in hospitals.” Cambodian returnee in her 40s who worked as a rubbish collector and construction worker in Thailand

“I do not have legal documents here and am scared to go to the doctor.” Vietnamese migrant in her 30s living in Cambodia with no fixed employment

“I didn’t have legal documentation and was scared of arrest.” Cambodian returnee in her 20s who worked as a construction worker in Thailand

“I was afraid to go to doctors as I was undocumented, and I also didn’t know how to find a doctor in any case.” Cambodian returnee in her 20s who worked as a domestic worker in Thailand

Barriers Even With Documentation

Close to 80 percent of the migrants working in Mae Sot, Thailand, are women, but few have work permits.44 The few that do have documents still struggle to access health care. Since the government demands a high registration fee for all documented migrants, employers advance workers money for the registration, but then take the permit as well as ID cards from workers and only give them photocopies.45 The employers use this as a security measure, but it adversely affects migrants when they are stopped by authorities, who only accept original documents. Similarly, health care can only be accessed with an original copy of migrants’ documents. This system places even those women who do have documentation in a vulnerable position.

Documentation Affects Return

Many returnees face difficulties in re-registration and application for ID cards and household/address registration. When migrants return home to Vietnam or Myanmar particularly, their ability to gain documents needed for health care depends on whether they have land or family remaining in the home country who can provide a “warranty” and address for the registration.

Out of 20 returnees interviewed by MMN’s researchers in Vietnam, more than 50 percent remained unable to get household registration books, or “ho khau”. Many children born in Cambodia to interviewed Vietnamese returnees do not have birth certificates. These two official documents are very important for them to access various public, social services such as health insurance (See Vietnam as a Country of Origin section). Many returnees want to buy health insurance, but the health insurance application requires they submit a household registration “ho khau” book. This remains the case under the New Health Insurance Law effective from 1 January 2015, except in the case of formal sector workers and staff of government agencies who are entitled to individual-based health insurance. The rest of the population is required to buy household-based health insurance, but those without a “ho khau” book cannot do so. The price of the insurance for an entire household is also prohibitive for many migrant returnees, even if they do have the required documentation.

Isolation

“There was no hospital/clinic. I was not allowed to go out. It was a remote place. And I was scared of being arrested.” Burmese returnee in her 20s who worked as a sex worker in China

“My employer didn’t allow me to go out, and I was scared of being arrested as I was undocumented.” Burmese returnee in her 20s who worked as a domestic worker in Thailand

Isolation is significant in migration for some communities and occupations, especially occupations primarily held by women such as domestic work. Factories throughout the region regularly insist that migrants live on site and restrict movement. Isolation is further worsened for women as patriarchal social norms restrict their movement out of community areas. As noted in the previous section and in the quotes in this section, lack of documentation further isolates women who cannot move out of homes or workplaces for fear of arrest. An inability to speak the destination area language further isolates women and migrant communities.

45 Ibid.
One migrant community in our study was particularly isolated, with MMN researchers and NGO informants noting their health suffered as a result. Svay Pak is an established Vietnamese community in the north of Phnom Penh where Vietnamese migrants have lived for over 40 years. Women's undocumented status, inability to speak the local language and lack of education factor into their struggle to secure employment in Cambodia. Many children in the community have lived there since birth and are not able to access education therefore perpetuating the same cycle that causes and maintains the community's poor living conditions, very poor health, and lack of access to health care beyond what NGOs provide. Another Vietnamese migrant community relying on fishing in Tonle Sap, Cambodia, faces a similar situation, as they, alongside local Cambodian communities, are highly isolated in the area.

Social networks in host countries can act to provide social protection in terms of money, assets, information and direct assistance.\textsuperscript{46} Women access health information and health care itself if they are less isolated in destination areas.

Language

Migrant women often have difficulties explaining their conditions or symptoms to health care providers who speak in a foreign language (See also Pharmacies section). This difficulty is enhanced by the fact that health can be a very sensitive issue, particularly when related to STI treatment or unwanted pregnancy. Health discussions also require a specific vocabulary, unrelated to everyday words a woman might have learned in the destination country. Finally, it can be difficult for migrant women to understand the treatment, specific instructions, or details of side effects that health care providers might try to communicate. Interviewees particularly spoke about a need for translated signage in hospitals, as well as interpretation. MMN researchers in China specifically noted that language was the biggest barrier for migrant sex workers trying to seek medical attention in Ruili, a city bordering Myanmar. Nearly all sex workers in Ruili are unable to speak Chinese.

“I can’t speak Khmer language, so it was very difficult to describe my situation and illness to the doctor.”
Vietnamese returnee in her 50s who worked as a fisher in Cambodia

“I need an interpreter at the hospital because of the language barrier. Some of the nurses from the Mae Sot hospital are sharp-tongued.” Burmese migrant in her 30s working as a salesperson in Thailand

Many Burmese migrant women mentioned in interviews that they seek health care at the Mae Tao clinic, Mae Sot, Thailand, where they can communicate in Burmese (Photo credit: John Hulme)
Bureaucracy

Complicated procedures can block women’s *de facto* access to health care services. Migrant women in all three destination countries in the GMS (Cambodia, China and Thailand) mentioned this. One Burmese interviewee in China particularly suffered ill health due to a spinal injury and a need for appendix removal. Further, her spouse has a disability. They were fortunate to be insured by China’s New Rural Cooperative Medical Care System (NRCMS) of health insurance. However, this was not without its problems: “Though the NRCMS program helped a lot, the procedure of reimbursement was too complicated and long. I had to submit many testimonials for identification and medical care.” As she could not read and write, the preparation for those testimonials was very difficult to accomplish.

“I hadn’t gone to hospital because of complicated procedures. My friends said that they required many documents and there were high costs as well.” Vietnamese returnee in her 50s who worked as a beverage vendor in Cambodia

Time

In most cases, the only available time for migrant women workers to seek health care services is during their day off, which not all women receive.47 With full-time jobs during daytime working hours, migrant workers do not usually have time off when government health services are open, forcing them to take an unpaid sick leave day. Time off is however not the only problem. Queues and waiting times in hospitals can be very long.

“I have to queue for a long time, and the problem cannot be treated in one visit. [I need to return].” Burmese migrant in her 30s working in agriculture in Thailand

“I have to wait for long hours or even the whole day to get treatment. Therefore, I want to recommend a better and quick system to access treatment.” Burmese migrant in her 30s working in agriculture in Thailand, when asked what she would recommend to improve migrant women’s health

“Although it costs only 30 Baht [1 USD, payment for services under Thai health insurance schemes], due to long waiting times, I go to the Mae Tao clinic [private clinic run by a Burmese doctor] to get treatment.” Burmese migrant in her 20s working in agriculture in Thailand

Cost

“We had no money. When I was 12, I got very ill. My parents couldn’t afford to take me to the hospital.” Vietnamese returnee in her 20s who worked as a fisher in Cambodia

“Everything was good if I had money. If I didn’t have any money, I couldn’t get health care.” Burmese returnee in her 30s who worked as a sex worker in China

“I had to send back money to my mom and daughter. So I couldn’t take care of myself and didn’t have enough money to go to the clinic. I just took traditional herbs and medicines.” Burmese returnee in her 20s who worked in a soft drink factory along the Thailand-Malaysia border

Cost is a key factor to access health care services, and migrant women need affordable consultation and treatment services. As we have seen above, migrant women from GMS countries have low incomes, in addition to the need to send remittance to their families. Reducing the cost of consultations, treatment and insurance will allow migrant women to look after their health when they need formal treatment.

“The cost of health care in Vietnam is cheaper and more effective than in Cambodia. Hence whenever getting sick, I always go back to Vietnam for health treatment.” Vietnamese returnee in her 50s who was a trader in Cambodia

Nearly all interviewed Cambodian women who returned from or were in Thailand stated that health care and treatment is better quality but more expensive in Thailand compared to Cambodia. Several women said their salary and minimal living costs made it easier for them to afford health care. For example, one domestic worker explained that she has suffered from heart problems for a long time, and when she migrated to Thailand she was able to have it treated. The cost of the treatment came to 31,000 Baht (1,000 USD), which her employer loaned to her and she has since repaid.

As the Policy section details, all migrants in Thailand regardless of documentation are eligible for health care insurance. The cost of that insurance is prohibitive depending on income levels. A woman in Thailand told interviewers: “Now the insurance card cost has increased, I cannot afford it.”48 Once migrants have the insurance however, it is highly affordable with many treatments costing 30 Baht (1 USD) per consultation (See Policies on Migrant Health Care in the GMS section for exceptions).

48 Costs of Compulsory Migrant Health Insurance are 2,200 Baht (68 USD) per year.
Discrimination

Migrant women interviewed had mixed experiences with discrimination at health care service points. Some said they faced no discrimination, and others emphasised that discrimination, judgement or stigmatisation were key deterrents keeping them away from hospitals. Discrimination can be based on nationality, migration status, occupation, income level, illness, or several of these intersecting identity markers or temporary statuses.

“Doctors at the hospital here (Thailand) take care of the patients. I don’t feel like I was discriminated against.” Burmese migrant in her 30s working in agriculture in Thailand

“Health service providers are friendly and patient and explain the directions in the hospital.” Burmese migrant in her 20s working in factory in Thailand

“Some health service providers are generous, but some are not. They very much look down on us as migrants.” Burmese migrant in her 30s working in construction in Thailand

“There is discrimination in treatment and it is very difficult to communicate and get the medicine.” Burmese migrant in her 20s working in agriculture in Thailand

“They discriminate against migrant workers: Nurses choose which patients go first, and it’s always Thai people. Nurses don’t speak politely to us, and the wait is longer than for other people.” Burmese migrant in her 20s working in agriculture in Thailand

Sex workers in Thailand particularly spoke about discrimination at hospitals. In a focus group migrant sex workers from all over the GMS said that they prefer to pay for their own health care and avoid government services because of “time and attitude”.

“I prefer to pay for my health care at a clinic and be treated like a customer rather than government services to be treated as an alien. We sex workers pay for all our rights. It’s normal... human rights are not free for sex workers.” Burmese migrant working as a sex worker in Thailand

“We (sex workers) had to pay more than other patients.” Burmese returnee in her 40s who worked as a sex worker in Thailand

Women in the region also report doctors reacting judgementally when they seek treatment for sexually transmitted infections. Doctors blame them for promiscuity or poor personal hygiene.49

---

Workplace Policies

“I had to fight for my health care benefits. My employer deducted the cost of health care from my wage.” Burmese returnee in her 20s who worked in a soft drink factory along the Thailand-Malaysia border

“I was not allowed to stop working even when I got sick. I had to solve my health problems by myself.” Burmese returnee in her 40s who worked as a sex worker in Thailand

“My employer did not allow me to leave the workplace to accept health care from a hospital or clinic when I was sick.” Burmese returnee in her 20s who worked as a sex worker in China

This report earlier detailed working conditions as a factor in preventing ill-health, for instance with proper occupational safety and health standards\textsuperscript{50} in place. This section looks at policies imposed by employers that restrict or enable women’s access to health care. The quotes above reveal that some women were not allowed time off, could not stop working, or had wages cut to pay for health benefits.

MMN research partners particularly saw a difference in employers of those who were documented and those who were not. For instance, Cambodian women migrating with documents (most often domestic workers) often did have employers who took care of their health care bills or paid into health insurance or social security schemes for them.

“I injured my knee at work, but my employer paid for my treatment.” Cambodian returnee in her 20s who worked as a domestic worker in Thailand

“I was able to treat a long term heart condition because of my access to quality private health care.” Cambodian returnee in her 20s who worked as a domestic worker in Thailand

“The clinic at my workplace was free to treat the injuries I got from the rock cutting machines.” Burmese migrant in her 30s working in a rock cutting factory in Thailand

\textsuperscript{50} As defined by the World Health Organization, “occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards.”
Women without documents felt their employers were generally unsupportive and uninterested in their health and wellbeing. Because they were undocumented, there was no government oversight of their working conditions, and therefore no incentive for the employer to be helpful. Moreover, when migrant women are undocumented, they more frequently lack a day-off, or have employers who keep their identity cards, restricting their movement during their non-working hours. In situations where employers keep migrants' identity cards, it is intimidating for migrants to ask for it to be able to go to a hospital when in need.

Though a majority of workplaces in our study (65 percent) did have sick leave policies, only 21 percent of women said they would receive pay or partial pay during periods of sickness.

“There’s no sick leave, but I could buy medicine at the pharmacy.” Burmese migrant in her 40s working as a salesperson in Thailand

Unfair Dismissals of Pregnant Women and Maternity Leave

Migrant women have very little recourse if they are fired or persuaded to resign when pregnant. In Thailand, a denial of paid maternity leave contravenes Section 57 of the Labour Protection Act of 1998, which requires that employers pay at least 45 days out of a potential 90 days of maternity leave. However, when approached by migrant women seeking remedies, Thai government officials, for instance, typically do not want to take time to overcome language barriers. Further, they feel less responsibility in any case to non-nationals who will have lost their visas when they became unemployed and be leaving the country soon.

“I left the factory when I was two months pregnant. They didn’t allow me to work.” Burmese returnee in her 30s who worked in a rock cutting factory in Thailand

“I get my salary cut if I miss work for any reason, including being sick. Pregnant women are especially unlucky when working at bars. When pregnant, I would be sacked or told to ‘take a break’ which is the same thing.” Burmese migrant working as a sex worker in Thailand

99 percent of Thai women go through antenatal care. Very few migrant women go. They are afraid of getting fired when employers find out they are pregnant. Doctors may tell the employer, or the employer may inquire when women ask for time off to seek health care.

Only 43 percent of women interviewed worked at places with maternity leave policies. If a woman does decide to return to work after giving birth, commonly she will find that her position has been given to someone else, and that she has effectively been turned away from her job without severance pay.\textsuperscript{54}

\textsuperscript{54} MAP Foundation and Clean Clothes Campaign (2014) “Migrant Workers in Thailand’s Garment Factories”, p. 29.
Policies on Migrant Health Care in the GMS

Policies on migrant health care in the GMS vary. Thailand and China have policies that are somewhat inclusive of migrants, but still contain exclusions in terms of what people and what illnesses are covered, in addition to barriers to de facto access to the health care. Lao PDR and Cambodia are also destination countries but have very little room for undocumented migrants in their health care policies. Thus migrants have limited access to public health care.

In countries of origin, migrant returnees and their children, including those born in destination countries, may have barriers to accessing health care due to lack of registration/documentation, or prohibitively high costs.

Across the region there are gaps in specific types of health care for migrant women, particularly care for mental health and sexual and reproductive health, as well as preventive health care.

Long term policies are lacking, and both immigration as well as health care policy for migrants changes often. This causes a lot of confusion and inefficiencies. Importantly, because no long-term policies that work toward integrating migrants exist in GMS countries, provision of public services does not take into account migrant populations, who therefore have difficulty staying healthy and accessing health care.

Sometimes health care policies and programming with a focus on migrants only cover HIV/AIDS without making available other health information and health care. Nonetheless, even with a greater proportion of attention, HIV/AIDS care remains inadequate, and a robust referral system across borders is needed, as is full anti-retroviral therapy (ART) provision to all people living with HIV.

A lack of labour rights is a large barrier to migrant women’s health. Without living wages, time off, maternity and sick leave, women do not have the resources to take care of their own health. Pre-departure trainings, where available, should include human rights training and information about health care and health insurance in countries of destination. Laws regulating recruiter and employer provision of health care or health insurance need to be enforced. Laws prohibiting employer and recruiter discrimination based on health status need to be strictly enforced.

Thailand as a Destination Country

Policies and Systems for Migrants

Health Care Coverage for Migrants in Thailand

In 2004, Thailand implemented a relatively open registration policy, Tor Ror 38/1, allowing migrants from Cambodia, Myanmar and Lao PDR to register for a one-year temporary ID card without registration fees and independent of an employer. With this registration, migrants are able to purchase health insurance and apply for a renewable one-year work permit. People who migrate through a recruitment agency are eligible to join national Social Security. Those who migrate informally, or whose employers do not register them for Social Security, are eligible for the Compulsory Migrant Health Insurance scheme.

The Thai government has wavered throughout the years between health policies focused on enforcing immigration status (health insurance only for documented migrants) and those that maximise coverage for migrants and their dependents, without regard to their legal status. The first are consistent with National
Security Council policy. The second see health as a human right and understand infectious disease affects all migrants, not only those with papers.

In 2009, health insurance was restricted to only registered migrant workers and their accompanying children up to age 15 years.

In 2013 the Compulsory Migrant Health Insurance scheme was expanded to include all migrants without regard to legal status. It provides individual coverage for dependents, family members and children of migrants. In March 2013, the Ministry of Public Health issued measures and guidelines for providing health exams and insurance to all migrants (from Myanmar, Lao PDR, and Cambodia) currently in the country. Notably, these measures referred simply to “migrants” rather than “migrant workers” as in the past. After the coup d’état in May 2014, the Thai military government announced further changes to health insurance for migrant workers. The 2014 policy is in Annex 2.

Compulsory Migrant Health Insurance

“For the migrant workers who have the migrant health card, the health care in Thailand is good and cheap.” Burmese migrant in her 30s working in agriculture in Thailand

“If you had the migrant health card, it was very useful. If you didn’t have this card, the hospitals wouldn’t care about you.”
Burmese returnee in her 30s who worked in a factory in Thailand

Compulsory health insurance for Burmese, Lao and Cambodian migrant workers in Thailand began in 1999, and Vietnamese migrant workers are now also covered. All migrant workers who register with a work permit must undergo a health exam. When the health exam was first mandated and implemented it was considered as a disease prevention measure among migrants. The exam includes a chest x-ray, blood sample, urine specimen, visual screening, and prophylactic medication. The examination screens for seven specific diseases and health conditions deemed of public health concern: Tuberculosis, Syphilis, Elephantiasis, Leprosy, Malaria, intestinal worms, addictive drug use, severe alcoholism, and “mental disorder”. Most of these conditions can be treated, and after treatment, the migrant can then fully register upon clearance from the doctors. If a person fails their health exam, their results are sent to the Thai immigration authorities so they can be deported (See Annex 2: MOPH Announcement on Health Check Up and Health Insurance for Migrants). As discussed previously in this report, the direct connection between health care providers and immigration authorities deters migrants from seeking professional health care.

Pregnancy is also tested in the health exam, but is not considered a condition that excludes migrants from documentation. The testing for pregnancy during the health exam is a contentious issue. This testing is done supposedly to benefit the health of the woman’s baby, because she would be excluded from required chest x-rays which may harm the baby. The pregnancy results, however, are made known to the employer, which breaches confidentiality of migrants’ health status and puts migrants at risk of losing their jobs.

Once a person finally qualifies and pays for health coverage, the insurance scheme includes treatment for a long-list of standard conditions, similar to the Thai Universal Coverage. It is often referred to as the “30 Baht scheme” because, once enrolled, migrants pay 30 Baht (1 USD) for most treatments. The insurance has some notable exceptions for migrants, including non-treatment of long-term conditions which require

55 The Nation (6 April 2015) “Workers from Myanmar, Laos, Cambodia and Vietnam now get better coverage.”
treatment beyond 180 days. Policy has wavered between covering and not covering ART of HIV/AIDS for migrants. As of 16 March 2015, ARTs are officially covered, but this policy is inconsistently implemented. In some cases this inconsistent implementation is discriminatory.

As of 1 April 2015, The Thai Ministry of Public Health and participating hospitals provide health exams for 600 Baht and health insurance, for 2,100 Baht (65 USD)/year or 1,000 Baht (31 USD)/3 months. Children under 7 years old pay 365 Baht (11 USD)/year.56

Social Security and Migrants

The Thai Social Security Office mandates that migrant workers from Myanmar, Lao PDR and Cambodia who enter from their home countries directly through regular channels, and those registered through a nationality verification process, be insured with Social Security.

However, Social Security excludes certain migrants, including those who are working in agricultural cultivation, fisheries, forestry or animal husbandry and whose employment is not continuous through the year; occupations not formally recognised under the law including domestic work and sex work; and those working on an ad hoc basis as required by the employer including itinerant or seasonal workers. Most of these excluded categories are heavily dependent on migrant labour.57 As there is no Social Security for the informal sector, informal workers and all those in the excluded categories above are not guaranteed certain labour rights such as sick and maternity leave. They are only eligible for Compulsory Migrant Health Insurance.

Migrants who are eligible for Social Security need to contribute 5 percent of their monthly income (not less than 1,650 Baht (50 USD) or over 15,000 Baht (456 USD)) at the time of registration for Social Security. The insurance covers injury or illness; disability; death; child delivery; child welfare; conditions of aging; and unemployment.58

The Labour Law and Migrant Women Workers

The 1998 Labour Protection Act establishes minimum workers’ rights, covering working hours, overtime, holidays, sick leave, maternity leave, severance pay and other basic employee rights.59

There are 605 labour inspectors in Thailand, responsible for monitoring conditions in 366,325 registered workplaces which employ 7.8 million workers.60 This is already a limited number, but becomes even more limited in the informal sector where most migrant women work. While all businesses with one or more workers are subject to labour inspections, labour inspection does not adequately cover workers in the informal economy. There are 38.3 million people in the labour force in Thailand.61

In addition to monitoring working conditions, labour inspectors also are mediators of disputes and are to look after social welfare of workers. Inspectors only speak Thai, however, which leaves many migrants unable to communicate with them, even if they were to come to their workplaces. Further, there is a lack of incentives for enforcement of the labour law.62

---

59 In addition to the Thai Labour Protection Act, other laws of concern to employers in Thailand include: the Social Security Act, the Workers Compensation Act, rules on minimum wages, the Labour Relations Act, the Alien Workers Act and the Revenue Code. See: http://www.bsialaw.co.th/en/laborlaw/laborprotection.html.
62 Ibid.
Many migrant women working in garment factories are excluded from protection of the Labour Protection Act because they are considered “piece workers”. Domestic workers are also excluded. They can buy health insurance, but considering the generally low wages they receive, it is very expensive. A first step was taken in 2012 with the adoption of the ministerial regulation No 14 (B.E. 2555) which introduced minimum legal provisions for domestic workers. But it is far from sufficient, in part because it does not recognise domestic work as formal work and provides for little enforcement. Thailand has still not ratified the ILO Convention N°189 concerning decent work for domestic workers.
There is also no labour protection system for sex workers. The lack of recognition of sex work as labour provides opportunities for corrupt police and other authorities to extort money from sex workers who are obliged to pay for their basic rights as workers.

For the past 19 years migrant women have been staffing the thousands of karaoke bars throughout Thailand, and to date they have never been included in any migration or labour policy. Several laws aim to bar them from working and migrating and mandate punishments for sex work: the 2008 Anti-trafficking Law, the 1979 Immigration Law, the 2008 Alien Worker Act, and the 1996 Suppression of Prostitution Law.
Issues Faced by Migrants: Gaps in the system

Aside from excluding most occupations in which migrants work, another weakness with Thai Social Security is that migrant workers are reliant on their employers to register them. Employers must also make monthly payments to the government equivalent to 10 percent of wages, with 5 percent deducted from the worker and the other half contributed by the employer. As it stands, migrants are given no proof of this arrangement, and may be cheated with the employer simply making the deduction but not contributing to the system, leaving the migrant without any health coverage. Transparency from employers is urgently needed.

Reports suggest less than 5 percent of registered migrant workers have access to Social Security. Further, migrants are not allowed to stay in the country long enough to see pension, unemployment, and most other benefits of the scheme they have paid into. Once employment contracts are terminated, for instance, they must return home, and there is no mechanism for them to collect unemployment compensation they are due.

Regarding Compulsory Migrant Health Insurance, even when migrant workers are entitled to access the scheme, they face obstacles. Migrants and NGOs report that in some cases, migrants are charged high fees at hospitals for treatment, though they should pay only 30 Baht (1 USD). Further, even when migrants are provided with health insurance, benefits and how to claim them are not always well explained.

In this MMN study, several migrants interviewed in Thailand were not convinced that Social Security or Compulsory Migrant Health Insurance were worth paying for. They saw them as costly, and further complained that health care is restricted to a single hospital. This single hospital restriction leaves them without health care if they work on a farm or construction site far from the hospital, or if their job site changes.

Under Thai policy, sex workers are effectively excluded from becoming registered migrants. The Immigration Act, B.E. 2522 (1979) contains a provision that allows non-Thai women to work as entertainers, but the policy is so stringent that the majority of entertainment venues do not meet the minimum requirements. And for those sex workers who can apply for documentation, they must also have a passport, which adds another barrier to access. Because migrant sex workers are excluded from any migrant registration process, they are excluded from Social Security and Compulsory Migrant Health Insurance and placed at risk of arrest and deportation. They also face forced HIV testing by the state and NGOs (as guidelines required under the Global Fund project, for instance). There are other related laws and programs which indirectly increase risks for sex workers, such as requirements for sex workers to use condoms 100 percent of the time. This is intended as an HIV prevention measure, however, if a sex worker is caught carrying condoms, then this can be used as evidence against them of committing a criminal act. Consequently, criminalisation of sex work affects migrant women's vulnerability to health issues and HIV. Criminalisation of sex work, often framed as anti-trafficking and “rescue”, reduces public health outreach efficiency within networks of sex workers who in some cases, had implemented successful sex worker-led health programming.

---


China as a Destination Country

Health Insurance and Health Care for Migrant Women in Yunnan

The Government of China aims to achieve universal access to basic health services by 2020, and to that end has increased input into the health sector since 2003. The proportion of health care costs that people in China pay out-of-pocket has reduced from 60 percent in 2001 to 35 percent in 2011.\(^\text{68}\)

Migrants have some limited access to health insurance in China, of which there are three types: 1) Basic Medical Insurance (BMI) programs for urban workers; 2) Urban Residents’ (non-workers) Basic Medical Insurance (URBMI) programs; and 3) New Rural Cooperative Medical Care System (NRCMS) for rural residents. Migrants are not covered under the first two urban schemes, which means that migrants living in cities do not have access to public medical insurance. Some migrants in rural areas are however covered under the third scheme (NRCMS), which raises funds to cover rural residents’ medical expenses for major diseases.\(^\text{69}\) To be eligible for this program, they must be married to Chinese citizens, however they need not have a marriage certificate.

Under this scheme, they can pay 70 RMB (equal to 11.6 USD) per year\(^\text{70}\) and receive medical care and maternity allowance on par with Chinese citizens. Women are encouraged to give birth in hospitals, and are given a maternity subsidy. The family planning office provides free contraceptives.


\(^{69}\) Recently reformed, the new system has new characteristics: 1) It clearly defines that the government (vs. individuals) shall fund the cooperative medical system. 2) It focuses on ensuring those who need the most help get it (vs. an equal distribution of funds). 3) Funds are raised at the county level (vs. only at the township and village levels).

The healthcare system in China has greatly improved in recent years. Reproductive health services have become more professional with the government’s promotion of available programs. Health education and consultation, antenatal care, postnatal care, and immunisations are available for free at the primary healthcare level. Family planning counselling and contraceptive services, including IUD insertion, abortion, and tubal ligation, are also free. In 2012, the proportion of newborn deliveries in public and private health facilities was 99.2 percent, and 25 percent of women sought antenatal care.71 Abortion is legal on all grounds in China, aside from sex-selective abortion for nonmedical purposes.72

---

**HIV/AIDS Policies and Care in China**

On World AIDS Day 2003, Wen Jiabao, then Prime Minister of China, committed the Chinese government to implementing a “Four Frees and One Care” policy to address HIV/AIDS. The policy is an important turning point in China’s history of AIDS response. The people’s governments at the county level or above are to take the following measures:

- **Provide free** antiretroviral medicine to rural and urban AIDS patients with economic difficulties;
- **Provide free** or low-cost medicine to rural and urban HIV/AIDS patients who are in economic difficulties as treatment of their unfortunate infections;
- **Provide free** counselling and primary testing to people who volunteer to receive these services;
- **Provide free** counselling and treatment to HIV infected pregnant women for the purpose of preventing mother-to-child HIV/AIDS transmission; and
- **Care** for orphaned or pre-mature children of AIDS patients, especially those with economic difficulties, including low or free compulsory education and relevant costs.

This “Four Frees and One Care” policy has applied only to Chinese nationals, but in recent years, as awareness of HIV/AIDS on the border areas has increased, the government in Yunnan has begun to supply some free services to migrants from Myanmar and Vietnam. The services have included follow-up care, regular CD4 testing, anti-virals, behaviour interventions, Tuberculosis (TB) testing and mother-infant transmission prevention.

However, due to the lack of formal legal applicability for migrants and also because of costs, not all migrants have benefitted from the “Four Frees and One Care” policy. Disparities exist even within Yunnan, where migrants in Ruili are more likely to receive free services, while migrants in other areas rarely benefit. Due to the lack of a universal standard, migrants’ access to these free services has been inconsistent.

For more information, please see Decree of the State Council of the People’s Republic of China No. 457: “Regulations on AIDS Prevention and Treatment” adopted at the 122nd Executive Meeting of the State Council on 18 January 2006, promulgated and considered effective as of 1 March 2006.

---

Social Security and Migrant Women

A 2011 law protects the rights of foreign workers to participate in wider social security programs.\(^{73}\) However, it is only applicable to non-nationals who hold an employment certificate and a foreigner residence permit certificate, such as a Work Permit for Foreigners, a Foreign Expert Certificate, a Permit for Permanent Foreign Journalists, or a Foreigner Permanent Residence Certificate. Migrants in urban areas holding one of these certificates are eligible for basic pension insurance for employees, work related injury insurance, unemployment insurance and maternity insurance. The insurance premiums are paid by the Domestic Work Unit (government unit for foreigners working in Chinese companies) and migrants themselves.

Sex Work

Sex work is illegal in China, and usually prosecuted as an administrative offense. The government vacillates between strict enforcement involving large scale crackdowns, and periods of low enforcement. The illegal status of sex work significantly affects migrant women in this sector. In terms of health, they are not able to register for health insurance, and primarily rely on NGO services where available. NGOs like Medecins sans Frontieres as well as local NGOs like Rui Kangyuan, provide treatment for illness, condoms, training on safe sex, and free abortion services.

Issues Faced by Migrants: Gaps in the system

Although the majority of people have access to healthcare, disparities for women in China still exist, particularly between urban and rural areas, and between migrants and residents generally. For an example in relation to HIV/AIDS treatment, see the box article on the previous page entitled: “HIV/AIDS Policies and Care in China.” While migrant women in rural areas, can be covered by the NRCMS, they are restricted to treatment in rural hospitals, which lack specialised physicians who can treat more complicated conditions. Disparities also exist between ethnic majorities and minorities due to differences in culture and religion, language and education, geography, diet and nutrition, health behaviour, and disease perception, which restrict equal access to the otherwise universal health services. Sex workers face particular exclusions from government health care.

“The urgent thing that the government can do for sex workers is to cancel the police punishment of sex workers who do not have temporary residential permits. Sex workers are always punished because the whole industry is illegal in China. The burden of the punishment is too heavy for the women to suffer, which results in them losing the ability to take care of themselves.”

Health Worker in China

While in principle social security is widely available to urban workers, in reality this is not the case for migrant women, who are rarely able to acquire the necessary certificates. Language or education limitations may often prevent women from understanding the proper requirements and procedures. Furthermore, certain certificates, such as the Foreign Expert Certificate, are impossible for migrant women from Myanmar to acquire, resulting in parts of the law not covering migrant women at all.

Cambodia as a Country of Origin
Policies and Systems for Departing Migrants

There are few laws and policies in Cambodia aimed at improving the treatment and protection of its migrant workers while abroad. However, Cambodia does have bilateral agreements with surrounding countries in the GMS in attempts to hold receiving countries accountable for the protection of their migrant workers. In the months following the 2014 Thai coup, there was a mass exodus of Cambodians from Thailand. Emergency measures were taken by the Cambodian government to make documented migration to Thailand easier. Since then, over 190,000 Cambodians have returned to Thailand with full or partied documentation. As discussed above, this has positive implications for access to health care for the migrant women who are among this number, as documentation often makes it easier to access health services in Thailand.

In 2011, Cambodia issued sub-decree 190 in an effort to improve protection mechanisms for Cambodians who migrated through private recruitment agencies. The law aims to regulate the deployment of migrant workers as well as ensure they are integrated safely in destination countries.

The health related provisions of the law are relatively few. It briefly highlights that employers are accountable for providing staff with suitable accommodation and with working conditions that comply with health and safety regulations. Employers are also responsible for organizing health insurance and medical checks for their staff both pre- and post-departure. In 2013 and 2014, the Ministry of Labour and Vocational Training also adopted 8 supplemental PRAKAS to sub-decree 190. Though sub-decree 190 provides more guidelines for employers than previous legislation regarding labour migration, it contains no provisions for penalties for not following those guidelines. Application and enforcement of current legislation is needed to provide meaningful effect.

HIV/AIDS Policy in Cambodia
Cambodian policy aims to educate and raise awareness among migrant workers and their employers as to how they can prevent and treat HIV. By promoting awareness of HIV/AIDS to employers and migrants, the policy aims to reduce stigma attached to people with HIV and to encourage and empower individuals to find employment. The policy has, however, been critiqued for overlooking gender equality in the work place.

---

74 Memorandum of Understanding between Thailand and Cambodia: on Bilateral Cooperation in Eliminating Trafficking in Children and Women.
76 Approximately 250,000 Cambodian migrants repatriated or were deported from Thailand in June 2014.
79 Ministerial or inter-ministerial proclamation.
Issues Faced by Migrants: Gaps in the system

The lack of enforcement has given rise to a situation whereby recruitment agencies do not implement Cambodia’s (otherwise fairly protective) laws and policies.

Article 2582 of sub-decree 190, requiring compulsory health screening, leaves migrant workers susceptible to discrimination.83 Though HIV screening is not listed as policy, migrants are routinely tested for this as well as pregnancy and other health conditions that employers sometimes consider undesirable. Recruiters often refuse to employ people with “undesirable” conditions – though this is not official policy.84 This is highly discriminatory. Anti-discrimination measures85 are not yet recognised or followed by employers or recruiters, due to lack of promotion as well as impunity for non-adherence.

Cambodia as a Destination Country

In terms of immigrant workers to Cambodia, the Cambodian Law on labour fleetingly references foreign workers in Cambodia. The law states that any foreigner wishing to work in Cambodia must possess full travel documentation and must not carry any contagious diseases.86

Those who are documented and employed under Labour Law regulations are entitled to Social Security. The National Social Security Law was introduced in Cambodia in 2002, and a National Social Security Fund (NSSF) was established in 2007 which covers Employment Injury Insurance (EII), the Health Insurance Scheme (HIS), and the Pension Scheme (which has not yet been implemented). The National Social Security Law protects all workers defined by the provisions of the Labour Law. Employers with over 8 workers are required under law to pay into the NSSF (0.8 percent of the workers’ monthly salary before tax). Social Security includes: medical treatment benefits, temporary disability benefits, nursing benefits, permanent disability benefit, constant attendance benefit, and survivors benefit.

A Health Equity Fund (HEF) was trialled and officially established in 2009 to enable those who have officially been identified as poor according to criteria from the Ministry of Health (around 18% of the population) to utilise public health services. The scheme provides support to identified “poor households” for expenses such as direct medical costs, transportation for patients, and food allowances. The HEF scheme has led to improvements in public health and health services, though the scheme has not been well advertised and the public lacks knowledge of it and how it works. It is also unclear whether the scheme applies to migrants or only Cambodian nationals.87

82 Sub-decree 190, Article 25: “Every time when the workers are sent and placed at work, the recruitment agencies shall properly record all information and data pertaining to each individual worker in the record book as determined”.
85 For example the ILO’s “Code of practice on HIV/AIDS and the world of work” (2001) aiming to empower and educate employers and migrant workers with HIV to allow fair treatment and employment without discrimination.
Issues Faced by Migrants: Gaps in the system

There is no room in Cambodia’s system for undocumented migrants, though it is well recognised now that many migrant workers within the GMS decide to migrate without documentation. Extensive research continues to show that undocumented migrants suffer poorer conditions and treatment than those who are documented. The vagueness of the Cambodian Labour Law is also a concern; further clarification and detail would be beneficial to both Cambodian and migrant workers.

While Cambodian women who are migrating legally through recruitment schemes are indeed experiencing better work conditions, and some employers are paying health costs, none of the interviewees for this study were provided with health insurance, as required under Article 21 of sub-decree 190. Oversight and sanctions for non-compliance need to be put in place.

The prohibition on migrant workers carrying contagious diseases creates major obstacles for people with HIV.

Finally, while health care is available at public hospitals in Cambodia, foreigners are charged a higher price (often double) as per each hospital’s pricing policies. It is not public policy to charge migrants more, but it is de facto practice in hospitals. [Gaps in health care system are filled by NGOs.]

Lao PDR as a Country of Origin

Low wages and a lack of jobs in Lao PDR lead many to migrate to Thailand for work. In 2002, Lao PDR and Thailand initiated a bilateral agreement to control migrant workers’ movement to Thailand. This Memorandum of Understanding (MOU) focuses on migrant workers’ documents and does not address access to health care other than to note the need for constructing health insurance mechanisms.

The Ministry of Labour and Social Welfare in Lao PDR made several decrees from 2002 to 2007 mandating health tests (not including HIV) for outgoing migrant workers, together with pre-departure HIV/AIDS education. The 2011 Law on HIV/AIDS Control and Prevention legislates provision of voluntary counselling and testing (VCT) and other HIV services. It mandates the right of migrants to information on HIV control and prevention and prohibits employment discrimination and termination based on HIV.

Currently a multi-departmental government programme on migration aims to protect and resolve conflicts with recruitment agencies, “raise awareness” about irregular migration, support shelters for trafficking victims, and establish Migrant Worker Resource Centres to provide migrant returnees, potential migrants and their families members with information, counselling and legal advice. The program also provides trauma counselling and pre- and post-test counselling for HIV/AIDS.

Yes, there are gaps in policy but they are filled by NGOs.

NGO worker


89 Ibid.

Outbound and Internal Migration in Lao PDR

In recent years government policies have limited agricultural land use, with the consequence of an increase in outbound migration primarily due to food insecurity.91 Further policies aiming to increase economic development and address inequalities have included resettlement schemes, which have led to increases in migration along border areas.

When migrants return home to Lao PDR, if they have been through official recruitment schemes, they are given a health check by the government. Once settled back in Lao PDR, returnees’ coverage by national social security and/or health care funds is extremely limited. In 2001, the first Social Security Organisation (SSO) for the private sector was established. Two medical insurance systems - Community-Based Health Insurance Scheme (CBHI) and Health Equity Funds (HEFs) - aim to provide benefits for the informal and non-salaried sectors.

Issues Faced by Migrants: Gaps in the system

As noted above, the MOU with Thailand does not address access to health care.

For returnees, as well as the wider population in general, the actual coverage of social protection in Lao PDR is very limited. Only 2.9 percent of people in Lao PDR are covered under the available public health care fund schemes, and 6.15 percent of the workforce are pension beneficiaries or contributors.92 Main barriers include low government administrative capacities and limited government revenue, which, as the main funding source for social assistance, is insufficient to cover, in particular, the very poorest people.

Fewer health facilities exist in rural areas as opposed to urban, and costs are often prohibitive.

Lao PDR as a Destination Country

There are approximately 200,000 migrant workers in Lao PDR, mostly from Vietnam, Thailand, Myanmar, and China employed in the construction sector.93 They are eligible for health care schemes and Social Security, if they are registered migrants. As per above, however, the numbers of even Lao people in these schemes is below 7 percent.

The Lao government has implemented a few health projects for migrants, particularly related to HIV. For instance, the Environment and Social Division of the Lao Ministry of Public Works and Transport and the government’s HIV project team are encouraging training on HIV prevention and safe migration in road construction.94

Issues Faced by Outgoing and Incoming Migrants: Gaps in the system

Several programs for both outgoing and incoming migrants focus on HIV/AIDS, but not health care more broadly. UN Women has further noted that migrants in Lao PDR face violations of the right to health, including absent safety measures at work sites, which may cause a host of health problems.95

Myanmar as a Country of Origin

Many Burmese have been outside the country for decades; others have only just begun migrating to other countries. When people return, they need to register with the government to receive house registration. Returnees to urban areas are finding this registration process easier than those returning to rural areas. If they get house registration, returnees are eligible for government health care. Without it, only private hospitals are accessible to them.

“If women would like to renew or change their national ID card, they need to go back to the place their household was originally registered. It is difficult for women to go back to their hometowns due to transportation cost and time. I would like to recommend the government change policy so that women are able to renew their ID card in every place inside the country.” Health care worker in Myanmar

Health care accessibility has increased as Myanmar has undergone political reform over the last five years. Because NGOs have also had comparatively more freedom and access, their provision of services has also increased, with several providing mobile clinics or hospital care.

“Now Medicines Sans Frontiers can work in many places, and many NGOs have increased provision of free hospital care. Also the government hospitals provide more services than before. There has been much progress in improving health care services in the past five years.” Representative from a health care organisation in Myanmar

A 2012 Social Security Law states that factories, workshops and enterprises that have over 5 employees must provide their employees Social Security cover. The employer pays 2.5 percent of monthly earnings; the employee pays 1.5 percent; and the government’s contribution is in the form of capital investment. The scheme provides free medical treatment, maternity benefits, occupational injury benefit, invalidity, old age pension benefit, survivors’ benefit and unemployment, in addition to a Social Security housing plan. Working towards implementation, the government is establishing workers’ hospitals, dispensaries, mobile medical units and branch offices.96

95 Ibid.
96 Health in Myanmar (2014) “Myanmar Health Care System.”
Issues Faced by Migrants: Gaps in the system

Fewer than 2 million people are covered by the government’s Social Security Scheme, and it is unknown how many of those are migrant returnees. The scheme explicitly excludes self-employed persons, construction workers, agricultural workers, and fishermen.

The health care system in Myanmar has limited national coverage. Border and rural areas have the most limited coverage. If people in rural areas need to go to an urban public hospital for general or specialised care, they require a recommendation letter from rural authorities, which is a barrier to access.

HIV prevention and treatment services for migrants, mobile population groups, and citizens are unaffordable and inadequate. Additionally, ART treatment in government health clinics is currently difficult to access, especially for HIV-positive people who are migrants and sex workers, because it is now limited by residency requirements that require evidence of house registration. The government does not cover all people, but targets people in border and rural areas. Thus, urban residents have better access to general health care but not HIV care, and the opposite is true for rural residents.

There is a lack of treatment referrals to neighbouring GMS countries for migrants with HIV. Further, related to immigration more generally, there are not standard protocols for cross-border information sharing or clear policy mechanisms for arrested and deported migrants from Thailand. This leads to the mass deportation of undocumented Burmese workers, resulting in challenges to coordinated and followed up HIV treatment.

Vietnam as a Country of Origin

Large numbers of Vietnamese migrate to other countries in the region. At least 100,000 Vietnamese migrants live in Cambodia, and 32,000 in China, according to some estimates. Apart from those who migrate informally, a total of about 80,000 Vietnamese leave every year under formal contracts to GMS and also other Asian countries. To service these migrants, the Vietnam government and the International Organisation for Migration have set up a Migrant Resource Centre in Hanoi and conduct provincial outreach activities with the Vietnamese Women’s Union.

The government also organises pre-departure training courses, but these are only for migrant workers under formal recruitment programmes; it is primarily men who leave under these formal schemes. This training is supposed to cover rights and responsibilities, contents of the contract, culture in the destination

---


country and life skills. Migrants are also supposed to have medical check-ups, which include a chest x-ray and abdominal ultrasound.102

According to Article 2 of the Law of Social Security, Vietnamese citizens are eligible for Social Security when they are working overseas under a formal labour contract for a defined term, as long as they previously paid compulsory social insurance premiums.

The government has an HIV/AIDS policy specifically for informal migration in border areas. In 2007, the Prime Minister’s office released the Decision on “Mechanism for Collaboration on Cross-border HIV/AIDS Prevention and Control” for collaboration with bordering countries on services such as counselling, testing, care, and treatment along border areas. This decision aims to establish an enabling environment for HIV/AIDS prevention and care in border areas.

When migrants return home, they can only access government health care if they are registered under “ho khau” rules, which mandate household and location-specific registration. A 2014 law helpfully allows some flexibility in registration for children under 6, who do not need to present a birth certificate for registration. This is especially important for children born outside Vietnam who may not have the certificate.

**Issues Faced by Migrants: Gaps in the system**

Migrants’ health is not prioritised in host countries when they cross borders informally and without documents (see especially sections on Cambodia and China).

Regarding pre-departure trainings, effective pre-departure training remains a challenge because of the variability depending on the recruitment agency, in terms of appropriateness of the content, the training methodology and the quality of trainers, etc.103

Some labour export recruitment companies are state owned, and insuring workers under Vietnam’s Social Security (which, as noted, Vietnamese migrants are eligible for even while abroad) would theoretically not be hard for them to do. However, this does not happen in practice. As of 2014, only 20 percent of all Vietnamese workers (migrant and not) had social insurance at all.104

Returnee migrants face major problems related to registration and documentation under “ho khau” rules. Some returnees for instance do not return to their places of origin - typically because of the lack of employment available in those areas. They then become classified as “overseas Vietnamese returning to their home country” (Viet Kieu hoi huong) and cannot get “ho khau” registration.105 Many Vietnamese returning home from Cambodia or China lost documents during long migration periods abroad, and some no longer have local family connections who could provide evidence of local registration.


“The current approach of addressing social protection through ‘ho khau’ [household registration system] appears to be ineffective and there is a clear need for the urban administrative authorities to support [internal] migrants [which often include migrant returnees] through subsidised Health Insurance (HI) cards and educational requirements of their children” Mr. Upendranadh Choragudi, International Coordinator, Progressive Redistributive Policies, ActionAid International.106

The “ho khau” regulations prevent returnee migrant women and their families from accessing myriad social services including health care, health insurance cards, marriage certificate registration, birth certificate registration, schooling enrolment, and even vocational training, loans, and job seeking in some sectors.

Regional Policies and Frameworks on Migration and Health

ASEAN

The number of migrants originating from Association of Southeast Asian Nations (ASEAN) member states is estimated at 13.5 million, 39 percent of whom are working in other ASEAN countries. In many origin and destination countries, the majority of the working population are employed in informal sectors of the economy, which are not fully covered by labour laws. One estimate is that 60 percent of migrant workers in ASEAN are employed in the informal sector with little or no social protection. In some countries, such as Thailand, migrant women are overrepresented in informal work, where they have less labour and human rights protection.

Importantly, the 2008 ASEAN Charter seeks to “…promote and protect human rights and fundamental freedoms…” and “to enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to opportunities for human development, social welfare and justice.”

“Enhanced well-being” for migrant women requires robust health care systems in ASEAN countries.

The 2007 ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers recognises the contributions of migrant workers, while also calling for improved coordination between sending and receiving states to increase data-sharing. Recognition and data sharing are important, but health rights protection is lacking in this agreement, and health care access is not addressed. The Migrant Worker Declaration is notably lacking in inclusion of migrant workers’ families and is unclear about whether undocumented migrants are covered. The implementation framework has faced political challenges and disagreements around the inclusion of undocumented migrants (which States remain divided on), and seven years after the Declaration, the implementation framework remains undeveloped.

The 7th ASEAN Forum On Migrant Labour in Nay Pyi Taw, Myanmar, resulted in recommendations for adequate access to decent working and living conditions for migrant workers, such as occupational safety and health (OSH), referral systems between countries of origin and destination, and cooperation between the countries of origin and destination. The inclusion of OSH here is important.

Regional Priorities from High Level Multi-stakeholder Dialogue on Migrant Workers’ Health and Access to HIV services in the ASEAN Region were set on 29 and 30 November 2011. Joint priorities were established for addressing migrants’ health and access to HIV services in the ASEAN region.

Most recently, the September 2014 Joint Statement of the 12th ASEAN Health Ministers Meeting included a commitment in Article 6 to “promote equitable access to healthcare for all groups within each Member State by reducing gender, geographical, social and financial barriers at all levels’ [emphasis added]. However, part of the statement is restricted to nationals; in Article 5 governments “commit to develop efficient and sustainable national health financing systems in order to enable nationals to access health services without suffering financial hardship.” This is good for returnees and should be encouraged, as should expansion of the scope to provision of universal coverage to migrants in destination countries as well.

With relation to HIV, in 2007 ASEAN governments in Cebu committed to “Put into place necessary legislation and regulations (including workplace policies and programmes) to ensure that persons living with HIV and affected groups are protected and are not subjected to stigma and discrimination, have equal access to health, social welfare and education services.” Implementation of this should be prioritised (See HIV/AIDS section).

Greater Mekong Subregion

At the GMS level, the March 2014 Mandalay Statement ‘Improving Access to Health Services by Migrants in Mekong Region’ was signed by representatives from Cambodia, Lao PDR, Myanmar, Thailand and Vietnam. GMS governments (not including China) laudably committed to improve access to health services for migrants:

“We pledge our firm commitment to improving access to health services by migrants. This requires multi-sectoral actions by public security, immigration, health, labour, social security, civil society and private employer constituencies. Close collaboration among agencies responsible for migrants’ health in host and sending countries is essential. The main bottleneck is financing health services for migrants and their dependants.”

Commitments to ensure access to health care for all ASEAN people’s and all people in the GMS are of utmost importance.

Migrant women urgently need governments to meet and monitor implementation of these commitments which would ensure de jure and de facto access to health care.

Sexual and Reproductive Health Issues Migrant Women Face in the GMS

“Although I paid money, the doctors didn’t want to treat vaginal infections/wounds.” Burmese returnee in her 20s who worked as a sex worker in China

This study found that migrant women in all areas of employment are experiencing violations of their sexual and reproductive health and rights (SRHR) in migration. In Thailand, for example, there have been cases of involuntary sterilisation after women give birth; pregnancy is tested in the annual health exam for migrants; and it is difficult to access contraceptive services or to report rape. In this study, migrant women in Thailand said they did not have information about specialised services for sexual or reproductive health, including abortion, or for rape or domestic violence. Women in China had comparatively more access to information as well as services (See Policies on Migrant Health Care in the GMS section). When asked questions about sexual and reproductive health, many respondents did not want to talk about it. Partly this due to social norms in a region where sex education is poor. Most women are reticent to speak about any sexual health problems or seek advice and treatment. As women are expected to abstain from sex until marriage, women fear being stigmatised as promiscuous if they talk about sexual health. These unhelpful norms lead women to ignore or keep quiet about sex, not to mention rights to make safe choices or to access reproductive health services. If they are sexually active before marriage, many women do not seek reproductive health services or buy contraceptives, for fear of being seen.

Contraceptives

“I asked my husband to use a condom, but he does not allow it.” Vietnamese migrant in her 30s living in Cambodia with no fixed employment

“To avoid getting pregnant, I took some pills and also use condoms, though I didn’t really understand the benefits of using condoms.” Burmese returnee in her 40s who worked as a sex worker in Thailand

Contraceptive use depends on ease of use, price and a woman’s relationship with her sex partner. For instance, women migrants from Myanmar in Thailand prefer oral contraception for convenience, ease and

---


expense. Unfortunately, some migrant women lack proper information on how to take oral contraceptives or may have inconsistent access to their preferred method, resulting in unplanned pregnancies. A minority of Burmese women take the injectable contraceptive Depo-Provera which lasts three months, but is relatively expensive for a migrant worker and requires taking time off work in order to get the injection at a hospital.

NGO staff in Cambodia report that when Vietnamese migrants suggest the use of contraception to their husbands, they are often punished physically or sexually as a result. Women who experience abuses rarely confront or report them to either authorities or organisations that can provide help.

**Abortion**

Some women who have unplanned pregnancies chose to keep the child; others seek out abortions. Migrant women in Thailand know about and use Postinor, an emergency contraception drug known as “the day after pill”. Migrant women throughout the GMS may also seek out traditional midwives who use unsafe methods for later stage abortions. They use herbal suppositories, strong massage, and/or insertion of sharp sticks, which may also result in complications requiring hospitalisation or leading to death.

“When my friend became pregnant while working as a sex worker, the Thai employer sent her to Kaw Thaung (Southern Myanmar) for an unsafe abortion with an untrained midwife. She put red medicine into my friend’s vagina, and massaged her pregnant belly hard. Blood came out after half an hour and then the fetus. The midwife charges depending on the month of the pregnancy - for aborting after 1 month of pregnancy, we need to pay 10,000 Kyat (around 10 USD). Some women die during these abortions. But no one cares about it. Burmese migrant workers are valueless even though we die.” Burmese returnee in her 40s who worked as a sex worker in Thailand

Options for safe abortions are limited. A study respondent in Thailand insinuated she would have chosen abortion but could not find one so gave birth instead. An NGO respondent in Cambodia indicated that women have little choice but to seek abortions from unsafe, unregistered and unhygienic clinics, as they are the only affordable option. Abortions are legal in China and Vietnam. However, legality is just one factor. Safety and hygiene must be prioritised and ensured in those two countries as well as all other GMS countries.
Pregnancy & Birth

Some migrant women have experienced forced and non-consensual, non-informed sterilisations at Thai hospitals (in the past and as recent as last year). Stories of these forced sterilisations make women wary of Thai gynaecologists’ assistance during birth, leading them to choose to deliver at home. Migrant women in Svay Pak, Cambodia, also reported that they often give birth at home despite known complications. They either cannot afford or are scared to use local hospitals. The home births are fine if well supported by a trained midwife, but can be dangerous if there are complications or the midwife present is not trained or properly equipped.

On the other hand some women find good health care when giving birth in Thai hospitals:

“Health care in Thailand is good. Medicine is very good. If we have migrant worker documents, the cost of health care is very cheap. When I gave birth in the hospital, I needed to pay 65 Baht (3 USD) for 3 days. They also gave me medicine. The hospital staff were hospitable. When I gave birth, I did not bring any supplies to hospital with me. In Myanmar, we need to bring everything including our own bed blankets. We need to pay for everything. However migrant women in Thailand without social insurance need to pay a lot for births and other care.” Burmese returnee in her 30s who worked as a domestic worker, a waitress at a restaurant, a factory worker and a salesperson in Thailand.

Our findings show that very few migrant women receive antenatal clinic care, and thus do not receive proper information for self-care during pregnancy. If a woman’s health is poor in pregnancy, not only does she need care but there are increased health risks to her baby after birth.

After birth many women in the GMS lack maternity leave (57 percent in our study worked at places without any maternity leave). Of those that did have maternity leave, 90 percent of women received no pay during the leave period. Whether they get maternity leave or not, child care costs are often unaffordable. Maternity leave varied for women across the study. In Thailand 50 percent of respondents said their workplace gave maternity leave (84 percent completely unpaid); in Cambodia 0 percent of respondents’ workplaces granted maternity leave; and in China 70 percent of respondents’ workplaces gave maternity leave (100 percent of which was unpaid).

“The employer did not allow us to bring babies to the work place. After my baby was three months old [and maternity leave over], I could not afford a babysitter to look after the baby. So I sent my baby with a broker to my parents in Mon state, Myanmar. You need to pay a broker 5,000 Baht (150 USD) for one baby [who they sedate/drug for the duration of the journey].” Burmese returnee in her 20s who worked in a fish canning factory along the Thailand-Malaysia border
HIV/AIDS

Multi-sectoral responses to HIV/AIDS in the GMS have finally managed to halt the increase in the number of new infections. In Cambodia, Myanmar and Thailand, the rate of new HIV infections fell by more than 25 percent between 2001 and 2012. Access to treatment has increased significantly in the region. In 2000, no HIV positive people in Cambodia were on ART, but by 2013, 87 percent of those eligible (around 50,000 people) were on ART, the highest in the region. While in Lao PDR, the numbers of people accessing ART increased from 1,680 in 2010 to 1,988 in 2011. Nevertheless, the coverage of treatment is far from comprehensive. In Vietnam, there are estimated to be around 250,000 people living with HIV. Of those probably 50,000 do not know their status, and 72,000 are receiving care, only 61,000 of whom are on ART.

Case from a Lao HIV clinic

When working in Thailand, a Lao woman in our study married a Thai man. She lived with her husband and ran a small grocery business at home. When she was unwell, her husband suggested she get a check up at the community health clinic. There she found out that she had HIV, and subsequently found out her husband was also HIV positive. They divorced and she returned to Lao PDR for treatment. Recently she has had more health problems, with a frequent fever and coughs. But she feels safe and comfortable staying with her parents, and has free-charge treatment in Lao PDR.

HIV/AIDS continues to remain an issue in the GMS and is exacerbated by governmental policies that exclude and often marginalise migrants, affecting migrants. Furthermore, voluntary confidential counselling and testing (VCCT) does not reach everyone, and where it exists it is not always linked directly to treatment, so there is little incentive to get tested.

The region lacks a systematic referral system between GMS countries for HIV positive migrants, as well as a lack of standard protocols for information sharing among health practitioners.

Antiretroviral treatment can easily be interrupted in migration. As a doctor in an HIV/AIDS clinic in Lao PDR told MMN: “Migrants come to treat HIV/AIDS at the centre. After some time when they get better and are feeling well, then they start to migrate again for work. Some do not continue taking medicine, only resuming when they get worse. Or if they become unwell, then they come back to our clinic.”

---


121 See Methodology section for explanation of inclusion of Lao case studies in this section.
“I started to suspect that I might be HIV positive when I was very sick. It was easy and free to test my blood and confirm, but I could not get ART and STI medicine in Mae Sot. I would recommend that migrants receive ART and STI treatment in destination countries. Without this, we need to go back and forth again and again for treatment in home countries. If we don’t need to spend money on transportation, we can earn more money, and we can continuously take the medicine.” Burmese returnee in her 30s who worked as a sex worker in Thailand

Existing HIV and AIDS education does not sufficiently reach out to the migrant population, especially women, due in no small part to gender and cultural bias (that only “bad girls” have casual sex and attending HIV and AIDS education implies that they are having sex and thus must be “bad”). There is also insufficient implementation of HIV/AIDS education during pre-departure training, where such training is available. Discrimination in the workplace is also common as in the case of the Lao PDR below.

Case from Lao HIV clinic

A Lao woman in our study with fairly good working conditions and an employer who supported her health care costs found out she had HIV while working in Thailand. She preferred to stay in Thailand after finding out her health status because she could earn much more there than in her hometown in Lao PDR where work is scarce. After her employer found out she was HIV positive, the employer sent her back home and did not allow her to work anymore. She is now in Lao PDR receiving regular treatment.

Other Sexually Transmitted Infections

An MMN partner spoke about providing STI information to migrants. Most women want to go to a hospital for sexual and reproductive health services, but they worry that if they find they have an STI they may not be able to fully treat it since their spouse is unlikely to also treat the STI (much less ensure any other sex partners he has also treat the same STI). Women fear their spouse will blame them for having the STI especially if the woman asks her spouse to also treat the STI he is carrying. Women may face repercussions in the form of domestic violence, divorce or infidelity.
Gender-Based Violence (GBV)

Gender-based violence targets women, affecting their mental and physical health. Patriarchal gender norms and socialisation in the GMS result in some men believing they are entitled to control women, even by violent means.

Migrant women face multiple barriers when trying to expose abuse, especially sexual abuse. Migrant women's right to stay and live in destination countries can easily be taken away from them, and communities often attempt to placate women, fearful that any action will bring negative attention to their community and thus threaten their security. Police are not active in following up on cases of abuse against women, particularly migrant women. And when the abuse has been committed by a family member in the migrant community, they claim it is a migrant affair and therefore not of concern to them. Even agencies mandated with the protection of refugees or migrants have sometimes been reluctant to encourage women to pursue justice.122

In a study on violence against women migrants from Myanmar in Thailand, 80 percent of respondents indicated that they had been victims of some form of violence, where violence was broadly defined to include physical, mental, and sexual violence. Reports of domestic violence were highest at 68 percent, with workplace violence at 61 percent.123

On the other hand, some of our respondents felt like they had escaped domestic violence by marrying men from other countries. One Vietnamese woman in China said that many of her friends who stay in their hometown were in violent relationships with their Vietnamese husbands. And a Chinese husband of one of MMN's interviewees told researchers that since finding a wife was so difficult in China, once he finally married a Vietnamese woman, he felt he must treat her well, for fear of her leaving the marriage.

Migrant women also face violence from employers.124 Because they fear losing their jobs, it is hard to complain, much less seek redress. Domestic workers, for instance, are often physically isolated with restricted access to local community support when they face violence and sexual abuse from male members of a household.

In the migration process itself, women also face risks of sexual violence. Anecdotal evidence suggests that it is not uncommon for border authorities and police to sexually and physically abuse women when they try to cross borders. Reports show that migrant women can be asked to “bribe” officials with sexual favours in exchange for passage.125

---

122 Ibid.
Conclusion

“Women's health is so much more than a medical issue; it is cultural, political, economic, and—above all—an issue of social justice.”126

For migrant women, considerations of health are always secondary to earning a livelihood and survival, and usually only arise when there is a problem. Migrant women self-treat with home remedies and pharmacy available medicine to save time and money. They also very often do not have de facto access to formal health care services. Migrant women’s self-care is often good and appropriate, but it could be better with better information and better job conditions that allowed them more time or financial flexibility. Sometimes self-care is not what is needed, and women do need access to doctors and hospitals. Governments need to continue working toward universal health care access in the GMS, as well as turn to self-treatment and pharmacies, ensuring that migrant women are able to take care of themselves in the best way possible.

Gender puts women at a disadvantage in this region as women are paid less than men, have access to less education, and often have less negotiating power than men at work, at home and in health care systems. Being a migrant increases the obstacles women face in securing working and living conditions to promote their health, while making it increasingly difficult to access appropriate health services.

Special attention to migrant women’s health needs to be paid by policies, including labour policies, with tailored programs that can reach migrant women with information on self-care as well as health insurance.

Recommendations

Significant policy and systemic changes need to be made so that migrant women are able to take care of their health in the best ways possible. Migrant women directly suggested many of the recommendations below based on their own experiences of self-care and health care in destination countries and upon return to countries of origin. MMN partners formulated other points based on collective analysis of research findings. Below are recommendations to governments, non-governmental organisations, and health care providers.

Recommendations for National/Local Governments

GMS governments have made commitments at ASEAN and GMS regional levels to improve migrant’s access to health services, ensure collaboration with one another about migrant’s health, protect migrants’ human rights and fundamental freedoms and ensure HIV/AIDS is tackled. These commitments must be implemented.

In addition, the findings from this research suggest that there are further ways to help migrant women take care of their health. They need health information, trained and regulated pharmacists and other providers, access to sexual and reproductive health services, translation/interpretation, a living wage, labour protections, and simplified documentation procedures. Some of these are simple measures that will impact migrant women's health in a very targeted way; others are systemic protections that will also enhance the rights of migrant men and of non-migrants. All of them are urgently needed.

For Both Origin and Destination Countries

1. Implement agreements made in the 26 March 2014 Mandalay Statement agreed by Cambodia, Lao PDR, Myanmar, Thailand and Vietnam government delegations. Agreements include a pledge to:
   - “improving access to health services by migrants”,
   - “multi-sectoral actions by public security, immigration, health, labour, social security, civil society and private employer constituencies”,
   - “close collaboration among agencies responsible for migrants’ health in host and sending countries”, and
   - recognition that “the main bottleneck is financing health services for migrants and their dependants”.127

2. As per the 2008 Association of Southeast Asian Nations (ASEAN) Charter “...promote and protect human rights and fundamental freedoms...” and “enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to opportunities for human development, social welfare and justice.”

3. Ensure that migrants are able to access proper and non-discriminatory HIV prevention, treatment, care and support services, including voluntary and confidential HIV counselling and testing in both countries of origin and destination, as per ASEAN Governments 13 January 2007 Cebu commitment to “Put into place necessary legislation and regulations (including workplace policies and programmes) to ensure that persons living with HIV and affected groups are protected and are not subjected to stigma and discrimination, have equal access to health, social welfare and education services.”

---

4. Ensure universal access to comprehensive, affordable, quality, gender-sensitive health services at all stages and across all locations, to achieve the highest standard of sexual and reproductive health; services include contraception; safe abortion services; services to ensure maternal health and nutrition; diagnostic and treatment services for STIs, HIV and AIDS, infertility and reproductive cancers; counselling; and comprehensive sex education. Universal access requires affordability and simplified procedures for documentation that are consistent over time, easy and low cost.

5. Ensure proper regulation/training of health care providers including pharmacists, including cultural awareness/training, communication skills and medically responsible dispensation of drugs. Promote and disseminate health care information through health care providers, particularly pharmacists who are migrant women's first contact with a health care specialist.

6. Conduct national/local campaigns to raise awareness on mental health, sexual and reproductive health (SRH), family planning and HIV, including in migrant languages.

7. Provide interpretation/translation in public services including health care systems and hotlines.

8. Enhance cooperation and integration between government and NGO services in health care provision to migrant women, ensuring sustainability and accountability of programmes and systems.

9. Legislate and enforce a living wage so that women will have the resources and capacity to look after their own health. Ensure access to justice and remedies for migrant women who do not receive legislated wages.

10. Expand labour categories for migrants to include “karaoke work”, so that workers at karaoke venues can register legally within the system and thereby access equal protections and benefits under all migration, labour, social security, occupational health and safety laws enabling them to manage their health and the health of their families more effectively.

11. Ensure portability of social security in the region, so that migrants who accrue benefits as documented workers are able to claim those benefits if needed. Migrants will thus have an incentive to join social security schemes.

For Countries of Origin

1. Labour attachés should be provided a team of staff, funding and training appropriate to respond to the needs of migrant women (such as training on how to provide assistance when migrant women face rape or abuse/violence, labour exploitation, or are unfairly dismissed due to pregnancy); provide an effective hotline.

2. Provide health and health services information relevant for migrant women (sexual and reproductive health rights, access to social security, how to make use of public health care etc, maternity leave) in pre-departure orientation programs/trainings. Monitor quality of those.

---

128 Recommendation from Civil Society at ASEAN Civil Society Conference/ASEAN Peoples' Forum (ACSC/APF) in March 2014 in Yangon, Myanmar, outcome of a joint session organised by the Asian-Pacific Resource and Research Centre for Women (ARROW), the Asia-Pacific Network on Food Sovereignty (APNFS), the Asia Pacific Forum on Women, Law and Development (APWLD), Asian Rural Women’s Coalition (ARWC), and Pesticide Action Network Asia Pacific (PAN AP).

129 See Footnote 2.
For Countries of Destination

1. Promote and enforce proper compliance of maternity and sick leave policies, as well as ensure access to justice for women who do not receive maternity and sick leave.

2. Provide information on policies, services, and health rights through different channels (multimedia, national, broadcasters, etc), targeting migrant women and with their full participation in design, development, management and evaluation.

Recommendations for NGOs

In some GMS countries, migrant women would be unable to reach meaningful health care services without the assistance of NGOs. MMN firmly recommends that NGOs and governments should work towards sustainability and accountability of government provision of health care. NGOs are well placed to develop and strengthen migrant women’s groups to advocate for systemic change, and they are able to provide migrant women and other key actors with information to support women’s self-care and health care.

1. Advocate for a sustainable system of health service provision for migrants. As necessary, this entails enhanced cooperation and integration between government and NGO services in health care provision to migrant women, ensuring sustainability and accountability of programmes and systems. Continue to model best practice health care services for migrant women.

2. Develop and strengthen migrant women’s groups to empower migrant women to understand and advocate for/defend their own rights.

3. Provide information to support migrant women’s self-care practices, including proper use of home and traditional remedies as well as preventive care. Provide information on at what stage of illness women should turn to formal medical care.

4. Provide rights-based gender sensitivity training for health service providers, employers, spouses, authorities, and associations of medical doctors and pharmacists on issues that affect migrant women’s health rights, including contraception, STIs, HIV/AIDS, sexuality and gender based violence, and comprehensive sexuality education.

Recommendations for Health Care Providers, including Pharmacists

This study found that when seeking care, migrant women’s first and preferred health professional contact point is pharmacists. Enhancing pharmacy support with health information provision, non-discrimination, confidentiality and translation/interpretation is key. These changes also need to be made in hospitals and clinics, so that migrant women can fully access care when needed.

1. Target health care information for migrant women where there are gaps in knowledge such as mental health, sex education, sexual and reproductive health rights, and gender-based violence.

2. Provide information to support migrant women’s self-care practices, including proper use of home and traditional remedies as well as preventive care. Provide information on the indicators of when women should turn to formal medical care.

3. Provide culturally sensitive, non-discriminatory services.130

130 As per article 12(1) of the UN Convention to Eliminate All Forms of Discrimination Against Women (CEDAW), all ratifying states “shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning.”
4. **Maintain strict patient confidentiality.** At all stages of any testing processes, migrant workers shall be afforded the right to privacy and dignity. The HIV and pregnancy status of migrant women shall remain strictly confidential.

5. **Provide visible signage and guidebooks in migrant languages** in hospitals and service centres. Provide migrant women at pharmacies with complete information on common medicines in different Mekong languages.

6. **Create a friendly and people-centred system of migrant health workers** in hospitals and health care service centres, with translation services.
Annexes

Annex 1. Project Partners

**Burmese Women's Union/Women's Galaxy (BWU/WG)** was founded on 8 January 1995 along the Thai-Myanmar border. BWU's central office is based in Chiang Mai, Thailand. BWU/WG has presence in four regions: along the Thai-Myanmar border (Mae Sot and refugee camps), China-Myanmar border, India-Myanmar border, and Myanmar (Yangon and Loikaw, Kayah state). The vision of BWU is to enhance women's participation in work for gender equality and social development and to strengthen women's role in political decision-making bodies. BWU's Mission is to empower women of Myanmar as an active workforce to build a society based on peace and sustainable development.

**Center for Research and Consultancy in Development (CRCD)** is a unit within the Southern Institute of Social Sciences in Ho Chi Minh City Vietnam. The CRCD specialises in undertaking applied, multidisciplinary and participatory research and consultancies on issues related to the social, cultural, economic and environmental development of Vietnam and its people. The CRCD is designed to contribute through applied, interdisciplinary and participatory research to the development of Vietnamese society that is socially, culturally, economically and environmentally sustainable.

**Empower** is a sex worker organisation and registered Thai Foundation with 30 years of experience advocating for the rights of all women doing sex work in Thailand by addressing current discrimination and stigma under the law and in society. Empower strives to create an avenue for women to access their basic human rights like decent work, education, good health, access to the law, community, social and political participation. Empower is organised and run by sex workers collectively reaching more than 30,000 sex workers each year, and some 50,000 women have enrolled in Empower over the past three decades. Migrant sex workers from the GMS are part of the leadership and a driving force within Empower.

**Faculty of Social Sciences (FSS), National University of Laos** provides higher education for Bachelor and Master degrees in the fields of geography, GIS, sociology, history, anthropology, tourism, hotel management, social work, social development, social impact assessment and political sciences, as are required by Lao PDR's plans for socio-economic development. FSS also collaborates and coordinates with multiple sectors - international universities, local institutions, government and inter-government organisations, and public organisations in Lao PDR and overseas - in order to promote, and conduct research and training.

**Legal Support for Children and Women (LSCW)** is a Cambodian non-governmental organisation, based in Phnom Penh and is registered with the Cambodian Ministry of the Interior. The vision of LSCW is a just and open society in which human rights and the dignity of the individual are respected within the rule of law. LSCW was initially established in 2002 and primarily focuses on women and children who fall victim to abuse and domestic violence. LSCW provides direct legal aid and support to victims of human trafficking as well as capacity building training, referral services, policy review and research.

**MAP Foundation** is a Thai non-governmental organisation that is firmly based in the Burmese migrant community, is a part of Thai civil society, and has linkages to regional and international networks. Started in 1996, MAP aims to improve the lives of migrant workers from Myanmar in Thailand by promoting labour rights, women's rights and empowerment, occupational health and safety, access to education, and health. MAP increases migrant workers’ access to information through two radio stations and direct activities in Chiang Mai and Mae Sot, and extends its reach across borders through networking.
Sex Worker in Myanmar Network (SWIM Network) was established in April 2011 by 35 female sex workers in 10 regions across Myanmar. SWIM Network works to create an enabling social environment that is free from discrimination against and harassment of female sex workers, that ensures equal opportunity and that does not stigmatise HIV infection or HIV.

Yunnan Health and Development Research Association (YHDRA, formerly known as Yunnan Reproductive Health Research Association) was established in March 1994. It was the first reproductive health related NGO registered in China. It was renamed YHDRA in 2007 to reflect a broadened scope and mission. YHDRA is officially registered with Yunnan Civil Affairs Department as the level one institute. YHDRA is under the administration of the Yunnan Science and Technology Association.

(Unofficial Translation by MMN)

MOPH Announcement On Health Check Up and Health Insurance for Migrants

Following the National Council for Peace and Order (NCPO)'s order No. 70/B.E. 2557 dated 25 June 2014, asking the Ministry of Interior to collaborate with the Ministry of Labour and Ministry of Public, and Immigration Bureau and other relevant offices to record migrant profile, issue identity card and perform health check-up to migrant workers and NCPO's order No. 73/B.E. 2557 with the subject “appointing a policy and management committee to manage problems related to migrant workers and human trafficking.”

In order to ensure smooth and efficient operation, MOPH is issuing the MOPH announcement as follows;

1. Request MOPH to provide health check-up service and health insurance to migrant workers with the following fees set out herewith
   a. Laotian, Myanmar and Cambodian migrant workers and their dependents who are living in Thailand: 2,100 Baht per health card-valid for 1 year
      • Health examination fee 500 Baht
      • Health insurance fee 1,600 Baht
   b. Children age less than years old: 365 Baht per health card-valid for 1 year
      • No health examination fee
      • Health insurance fee 365 Baht
   c. Other groups as defined by the MOPH committee to manage migrant health insurance fund

2. Request health facilities under MOPH to implement the measures and guidelines on health check-up and health insurance for migrant workers set by the MOPH B.E. 2557

3. MOPH announcements, measures and guidelines on health check-up and health insurance that already existed before this announcement remain valid as long as they are not contradictory or against the MOPH measures and guidelines on health check-up and health insurance for migrant workers that is adhered to this announcement. This announcement shall take effect immediately.
Announced on 26 June B.E. 2557 (2014) Mr. Narong Sahamethapat, Ministry of Public Health Permanent Secretary for Minister of Public Health

Measures and Implementation Guidelines for Health Check-Up and Health Insurance for Migrant Workers, Ministry of Public Health, 2014

Following the National Council for Peace and Order (NCPO)'s order No. 70/B.E. 2557 dated 25 June 2014, asking the Ministry of Interior to collaborate with the Ministry of Labour and the Ministry of Public, and the Immigration Bureau and other relevant offices to record migrant profile, issue identity card and perform health check-up to migrant workers and NCPO's order No. 73/B.E. 2557 subject “appointing a policy and management committee to manage problems related to migrant workers and human trafficking”, MOPH has therefore released the measures and implementing guidelines on Health Check-Up and Health Insurance for Migrant Workers, 2014 as follows;

1) Policy
   (1) All migrant workers should obtain health protection
   (2) All migrant workers should undergo health check-up and be enrolled in health insurance set by MOPH.

2) MOPH implementation measures
   MOPH’s mandate on health care include the following 4 key main areas of activities
   (1) Perform annual health check-up
   (2) Curative care
   (3) Health promotion and preventing and controlling diseases
   (4) Disease surveillance

3) Target populations include all migrant workers from Lao PDR, Cambodia, and Myanmar and their dependents who are living in Thailand

4) Criteria for health check-up and health insurance
   (1) Perform health check-up and enroll all migrant workers in a health insurance scheme.
   (2) Implementation Period
      • Request health facilities to register health benefit package for migrants after health check-up and sell health insurance every day or follow their operational plans, starting from 26 June 2014 onwards.
      • Medical certificate for health insurance/social security card is valid for 1 year after health check-up.
      • Health insurance card is valid for 1 year after purchasing or depending on additional conditions set by the committee.
(3) Fees for Health Check-Up and Health Insurance

(i) Migrant workers from Lao PDR, Cambodia and Myanmar and dependents

Health card fee valid for 1 year costs 2,100 Baht

- Health check-up: 500 Baht
- Health Insurance: 1,200 Baht

(ii) Children under 7 years

Health Insurance card valid for 1 year costs 365 Baht

- No health check-up fee
- Health insurance card: 365 Baht

(iii) Other groups of migrants as determined by the MOPH committee on Migrant Health Insurance Fund Management.

In case Migrant workers are subject to return to their countries under any ACTS, requesting for reimbursement of health insurance fee could be done based on the remaining portion.

(4) Health facilities to provide health check-up and health insurance should follow health service region

(5) In peripheral level, Provincial Health Office (PHOs) is in charge to determine service areas. Department of Medicine, Bangkok Metropolitan Authority (DOM-BMA) takes in charge in Bangkok and determines its service areas as appropriate. General guidelines are set as follows.

a) Services for health check-up and health insurance should be offered at the same health facility and at the province where migrants registered/stayed. This exemption is given to migrant workers in sea- fishery sector. They are allowed to utilise services at 22 coastal provinces.

b) Migrants who passed health check-up with valid medical certificate, in case of changing employer or moving to another province, there is no need for them to repeat health check-up.

(6) Only MOPH standard form developed for the migrant health check-up should be used. Health check-up results must be processed to MOPH

(7) Documents required for health check-up from migrants include

1. Any documents as determined by MOI
2. 500 Baht fee for health check-up
3. 1,600 Baht for health insurance fee or as determined additionally by MOPH

(8) Health service facilities should announce and make the public aware of this service. Facilities, staff, equipment and other medical supplies should be prepared and in place so that the services are given smoothly, quickly and meet the standard.

(9) Health check-up should be complete within a day and medical certificate should be provided to migrants within 3 days after completion of health check.
(10) Health service facilities should report to MOPH on health check-up registration and number of insured migrants as well as sending the portion of health insurance fee for administration and medical management that need to be administrated by central level to MOPH with 5 working days to allow proper checking and allocation of money.

(11) Health Insurance Card Format should follow the design set by the MOPH or use the temporary work permit card issued by the MOI that indicates the contracted health facility.

(12) Guidelines for Health Check-Up

1. Health Check-up should follow the guidelines set for monitoring the standard of health check-up and treatment as follows.

Lung radiography (big/small film), if found suggestive for TB, AFB sputum test should be followed.

Perform VDRL test and micro Filariasis test - if positive, then Health Check-up result should be classified as category 2, and treatment should be provided. If the result indicates Syphilis at stage 3 or Filariasis at a stage in which symptoms are deemed of public health concern, then Health Check-up result should be classified as category 3.

Provide DEC-300 mg (single dose) to all Burmese migrants with direct observation. After 30 minutes, blood sample for Filariasis test must be collected. If the result is positive but physical condition is deemed of public health concern, then Health Check-up result should be classified as category 2. To treat migrant with positive Filariasis, 300 mg – Diethyl Carbamazine (DEC) treatment should be provided every 6 month for the duration of 2 years and make sure that the last two blood tests show negative results. Be aware that taking DEC to control Filariasis may generate false positive results for amphetamine tests, or have adverse effect to fetuses, therefore it is suggested that health facilities should do a urine test before performing other tests.

Perform urine amphetamine test - if positive, then Health Check-up result should be classified as category 3. The purpose of urine amphetamine test is to prevent drug use, so it should be noted that taking DEC to control Filariasis and some medicines may generate false positive results for amphetamine test. If migrant wants to repeat the test, s/he must be responsible for the cost.

Perform pregnancy test for female migrant workers. The test should be done before lung radiography and administration of DEC as X-Ray and DEC may cause fetus deformity.

Perform leprosy test - if result is positive, and symptom is not deemed of public health concern, medical check-up result should be classified as category 2. Following the Leprosy treatment system, a confirmation test must be done and patient should be referred for further treatment. Leprosy cases must be reported to respective PHO (For Bangkok reports to Rajprachasamasai Institute, DDC- MOPH).

Provide 400 mg albendazole to all migrants to control intestinal worm.

Perform other health examination if indicated by physician.

2. Health check-up for children (depending on physician’s decision)

- Children age 0-15 yrs old, growth development monitoring should be performed according to their age e.g. examine general appearance and growth development, evaluate nutritional status and examine oral health etc.
3. Health check-up result is classified into 3 categories as follows

1. Category 1: normal

2. Category 2: passed but found disease that needs to be controlled and treated e.g. TB, Leprosy, Filariasis, Syphilis, and intestinal worm

3. Category 3: failed- due to the following reasons
   a. Unfit for work (based on physician opinion)
   b. Found disease(s) that prohibited migrants to work in Thailand include 1) TB at contagious stage, 2) Leprosy - at the stage that physical symptom are deemed of public health concern, 3) Filariasis - at the stage that physical symptoms are deemed of public health concern, 4) Syphilis stage 3, 5) Amphetamine test positive, 6) Alcoholism, 7) Psychosis or intellectual disability

Note:

- For Category 2: All health facilities under DOM/BMA and PHOs should provide treatment to migrants whose Health Check-up result is classified in this category. Referral mechanism is dependent on the policy and guidelines set by DOM/PHOs.

- For Category 3: Migrants who are classified in this category, a red colour stamp “Deportation” sign must be put on their medical certificate. In Bangkok a copy of medical certificate should be sent to the Immigration office at 506 Soi Suan Plu, Sathorn, Bangkok 10120. In other regions, a copy of the medical certificate should be sent to Immigration office in that area or nearby province as well as to the local police station to control and health facility to coordinate on medical treatment before deportation.

4. Reporting the results of health check-up and health insurance

- In the case of “Fit for work/passed” (category 1 and category 2), the health facility should give the medical certificate in sealed envelope with signature and stamp with the hospital emblem to the migrant for work permit processing. A copy of medical certificate must be sent to DOM/BMA or PHOs for further analysis.

- In case of “Unfit for work/failed” (category 3), the medical certificate should be processed the same as fit for work/passed category. A copy of the medical certificate must be sent to the immigration office as mentioned above. The health facility must coordinate on medical treatment before further deportation.

- Following the MOPH reporting system, on a monthly basis the contracted health facility must report on results of Health Check-ups, number of insured migrants, and health treatment accordingly. PHOs and BMA should monitor completion of the report to be submitted.

5. In completing the medical certificate, the following information must be complete in the form

- Out- patient number
- Name of health facility (Typing or Stamp)
- OPD card with name-surname of migrant, age, address (follows ID card/Passport), if there is no ID card; then bio data must be collected (e.g. finger prints, photo, iris)
• Nationality and race: in case of Myanmar nationality, their race e.g. Burmese, Karen, Mon or Shan etc should be recorded.

• Address in the country of origin (please specify at township level e.g. Myawaddy, Kaw Thaung, Dawei, Mawlamyaing etc.

• Health check-up result (one of 3 categories described above)

(13) Inclusive Health benefit package

Health benefit package include

1. General medical treatment and rehabilitation. These services include

   • Medical consultation, diagnosis and treatment, Child delivery and neonatal care (after 28 days of birth), Rehabilitation care, and Alternative medicines that are already endorsed by the medical license committee.

   • Dental care (tooth extraction, filling, and cleaning)

   • General diet service and patient room

   • Medicines and medical suppliers that are listed under the nation drugs list

   • Referral care

   • Immunisation service (0-15 Yrs)

2. High cost care-under the conditions set by the Migrant and Mother and Child Health Insurance Administrative Board (MMCHAB)

3. In case of accidents migrants are eligible to utilise services at the registered hospital. However this may be amended by PHOs/DOM. As for seafarers, they are eligible to utilise services at 22 coastal provinces. Health service provider(s) should collect service fees from the (primary) migrant insured hospital. As for OPD case, reimbursement from the insured hospital to the serviced hospital must be at real cost and should not exceed the rates set by Health Insurance Group (HIG). In case of high cost care, reimbursement should follow the rates set out in the Medical Treatment Costs Guidelines using Diseases Related Groups Criteria.

4. Referral mechanisms

In the case of referring a patient from the hospital where a migrant registered to another hospital for further treatment, the registered hospital should take responsibility to reimburse the health care cost to the 2nd hospital where the migrant is referred to. In case of referral occurred within a province/Bangkok, reimbursement should follow the agreement set between health service providers in that province/Bangkok. If referral occurs across a province/Bangkok, the registered hospital should reimburse to the 2nd hospital at real cost, but should not exceed the rates set in the HIG/PSO guidelines. For inpatient service, reimbursement should follow the rates set out in the Medical Treatment Costs Guidelines using Diseases Related Groups criteria. Additionally the hospital should send a letter to the governor/authorised person, asking for his/her permission to referral migrant across the province and migrant’s photo must be attached with the request letter.

In case of referral with the health service providers that are not part of the migrant health contract service such as university hospitals or private hospitals, then reimbursements for both OP and IP services should follow the same principles that apply with the contracted hospitals.
5. Controlling diseases in migrant population

- Prescribe DEC 300 mg-single dose to Burmese migrants and drug must be taken with direct observation by health staff and Filariasis blood testing should be done after 30 minutes taken the medicine.

- If the result is positive, with no obvious symptom that are of public health concern, health check-up result should record as category 2. And DEC-300 mg must be given every 6 months for 2 years and until the last 2 consecutive blood testing shown as negative results.

- For Leprosy, if the result is positive with no obvious symptom that could be of public health concern, health check-up result should be recorded as category 2. However testing should be repeated to confirm the diagnosis and free of charge treatment must be provided accordingly. Then the respective PHOs should follow up the migrants. In case of Bangkok Rajprachasamasai institute, DDC/MOPH should be notified to follow up the migrants.

- Albendazole 400 mg must be prescribed to all migrants to control intestinal worm.

6. Disease surveillance in migrant population

Inform health coordination committee at district level to surveillance diseases in mobiles and migrants and their community.

Mobile and migrant populations should be classified into 2 categories.

- Category 1: Migrant workers who crossed the border to work in the province e.g. domestic helpers, farmers, labours, seafarers, refugees with or without foreign ID cards plus known or unknown address.

- Category 2: Migrants who crossed the border to seek medical treatment and returned to their home country afterward.

- Health coordination committee at district level should report diseases under surveillance following BOE-506-507 reporting system. Diseases under surveillance should include Chikungunya, Plaque and re-emerging diseases. HIV/AIDS, NCDs and Occupation related diseases are not requested.

- In case of outbreak, individual case investigation must be performed.

7. Anti-retro viral treatment to be provided as determined by HIG/PS-MOPH

8. In case of any dispute related to health benefit package or health service coverage, the request should be considered by MMCHAB on a case basis.

(14) Exclusive Health benefit package

Health benefit package does not include the following services:

- Psychosis
- Drug rehabilitation in accordance to (Drug) Law
- Car accident case that is protected under the passengers protection act
- Infertility treatment
- All means of artificial insemination (IVF, GIFT etc.)
- Sex change
• Cosmetic treatment without medical indications
• Any medical consultations that are unnecessary or no indication
• After 180 days of treatment as in patient with the same disease, except there is complication or medical indications.
• Treatment under experimental phase
• End stage of renal failure treatment: Peritoneal dialysis and Haemo dialysis
• Organ transplant
• Synthetic tooth

(15) Health promotion and disease control services cover:
• Provision and continuous use of the individual health card for migrants. This includes child health card.
• Provision of ANC to promote the health of pregnant women as well as providing post natal care.
• Provision of medical consultation for high risk groups.
• Provision of ARV to prevent mother-to-child transmission.
• Provision of family planning services.
• Provision of home visit and home health care.
• Provision of knowledge on health to individual migrants as well as individual families through migrant health volunteers and other media such as printed materials.
• Provision of counselling and promotion of participation of migrants.
• Provision of oral care (both promotion and prevention), particularly with high risk groups for tooth decay-fluoride supplementary will be provided.
• Disease control service.

(16) Health insurance for migrants who moved across a province: in the case of moving across a province, the employer/migrant should inform the registration administrative office in the province where the migrant is registered and indicate the name of the new employer and his/her address. After that this change should be informed to respective PHO/DOM with the supporting documents attached. Respective PHO/DOM then collect the migrant health insurance card and sends a letter to the new PHO/DOM where the migrant should be insured. Based on the remaining portion left, the health insurance fee must be transferred to the new PHO/DOM. Under this condition, the migrant should be eligible to utilise health services at the old insured place until the change has been complete.

(17) Any implementing modalities, criteria and methods that are beyond the guidelines set out herewith such as introducing motivation strategy in selling health insurance and new health insurance fees set could be imposed with endorsement from the migrant health insurance fund board.
5) Administration and Management

(1) Central level Migrant and Maternal and Child Health Insurance Fund Administrative Board (MMCHAB) and Health Insurance Group (HIG)/Permanent Secretary Office are the main offices responsible together with relevant offices.

(2) At provincial level and health facilities in the area
To streamline the administration and avoid duplication of works at the operational level, Provincial committee is responsible to be the main administrative body.

(3) Budget administration
The measures set out by MOPH should be followed. It is assigned to Department of Medicine-BMA, Department of Health, or PHOs to monitor and supervise the implementation.

6) Financing and Accounting System
To follow the decision made by the Migrant and Maternal and Child Health Insurance Fund Administrative Board

7) Evaluation: Evaluation will be assessed on the following key areas: coverage of eligible migrants, service satisfaction, quality of services, and cost recovery of health facility by PHOs/DOM-BMA/DOH/HIG - PSO

8) Responsible office: Permanent Secretary Office (PSO) Ministry of Public Health

26 June 2014
# Annex 3. Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>BMI</td>
<td>Basic Medical Insurance</td>
</tr>
<tr>
<td>CBHI</td>
<td>Community Based Health Insurance Scheme</td>
</tr>
<tr>
<td>EII</td>
<td>Employment Injury Insurance</td>
</tr>
<tr>
<td>GMS</td>
<td>Greater Mekong Subregion</td>
</tr>
<tr>
<td>HEF</td>
<td>Health Equity Fund</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Insurance Scheme</td>
</tr>
<tr>
<td>MMN</td>
<td>Mekong Migration Network</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>NRCMS</td>
<td>New Rural Cooperative Medical Care System</td>
</tr>
<tr>
<td>NSSF</td>
<td>National Social Security Fund</td>
</tr>
<tr>
<td>OSH</td>
<td>Occupational Safety and Health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>SSO</td>
<td>Social Security Organisation</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>URBMI</td>
<td>Urban Residents Basic Medical Insurance</td>
</tr>
<tr>
<td>VCCT</td>
<td>Voluntary Confidential Counselling and Testing</td>
</tr>
</tbody>
</table>