CHAPTER II

ESSAY

Myanmar Migrant Workers in Thailand

2.1 Introduction

While voluntary migration purposely benefits the quality of life of household members of the individual migrant workers, the quality of life of these migrant workers themselves in the new land has lost ground. Bollini & Harald stated in Health Needs of Migrants in World Health (1995, p.20) that

> *"Migration, even when it is voluntary and planned, it is a stressful life event. Their social and psychological conditions contribute to a worsening health status, and to problems within the family, at work and at school."*

Illegal stay in the host country constrains undocumented migrant workers from receiving assistance and also reduces availability and accessibility to public services. Undocumented migrant workers were mentioned by Gardner & Blackburn (1996) in the Population Reports as among the world's most vulnerable people, who often have urgent health needs.

Even though migrant workers legally entered the host country with a good health status, studies conducted in a number of countries have indicated that people of migrant communities had a worse health status than native residents. In particular, higher incidences of infant mortality, congenital malformations, work-related injuries

and disability have been reported. Occupational accidents and disability among migrant workers have led to early retirement or return to their countries of origin when they become too disabled or too sick to work. Other health conditions among migrants include mental disorders, drug abuse and domestic violence. These are attributed to various barriers in access to health care such as financial, language, cultural, racism, discrimination and lack of attention to the needs of migrant communities within the host health system (Bollini, 1993, Bollini & Harald, 1995).

Issues on international migration were initially brought to the attention of United Nations in the 1994 International Conference on Population and Development (ICPD). The Programme of Action adopted by the UN General Assembly in July 1999 called for a comprehensive international approach to deal with international migration. The ICDP urged governments of both countries of origin and of destination, including international cooperation to

> *".. to intensify efforts to protect the human rights and dignity of migrants irrespective of their legal status; provide effective protection for migrants; provide basic health care and social services..."* (UN General Assembly, 1 July 1999).

This statement indicates a growing concern about problems faced by migrants and the need to raise international awareness.

International migration is an ongoing phenomenon in every region all over the world. The significant flow of migrants is from less developed to more developed countries (Weeks, 1996). In the mid-1990s, about 125 million people lived outside their country of birth or citizenship, which accounts for about 2 percent of the world's population and are expanding by 2 to 4 million annually. Their increasing numbers in

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each country and region vary substantially. These migrations may be voluntarily, such as migrant workers or involuntarily as refugees. According to the International Labour Organization (ILO), there are over 90 million migrant workers and their families currently residing, legally or illegally, in a country other than their own. There is no continent, no region of the world, which does not have its contingent of migrant workers. Migration has leaped to the top of policy agendas in many of the world's major economic powers (Martin & Widgren, 1996 and ILO, 1999).

There are nearly as many Thai workers overseas as there are foreign labours in Thailand. Much of the labour migration in Thailand is illegal from its poor neighboring countries as the demand for cheap labour has outrun local supplies. This demand generally includes unskilled labour in the difficult, dangerous and dirty jobs, which are frequently turned down by local Thai labours (Archvanitkul & Guest, 1999, Martin & Widgren, 1996).

Similar to the situation of migrant workers in any host country, especially in developing countries, most of migrant workers in Thailand have been living in poor conditions, are highly vulnerable, and are in high need for health and social services (Caouette, Archvanitkul and Pyne, 2000 and Nang Lao Liang Won, 1999). Thailand's public health officials often pledge their policy to provide necessary health services to every people residing in Thailand on a humanitarian ground, regardless of legal status. While Thailand's government health services have limited resources to cope with large numbers of migrants, the quality of service for these migrants often become inadequate (UN General Assembly, 2 July 1999).

Most studies on migrant workers in Thailand, conducted in recent years, provide information regarding managing the flow of migration, the general situation of migrant workers, reproductive health needs including HIV/AIDS related issues, and the health situation at border provinces. The dominantly high number of migrant workers from Myanmar among all migrant workers in Thailand, plus their vulnerability are the reasons making them the focus in most studies.

The health of migrants is a more dynamic and complex phenomenon compared to resident population (Migration and Health Newsletter, 1/2000). Common factors affecting the quality of life of migrant workers from Myanmar in the context of the Thai culture and value system are reviewed and analyzed in this study. It is hoped that this will help to –find some practical measures to improve the overall quality of life of these migrant workers.

2.2 Migration and the Migrant

There are many derivative terms of "migration" and "migrants" used in the literature, depending on the purpose and perspectives adopted (Archvanitkul & Guest, 1999, ILO, 1999, Gardner & Blackburn, 1996 and Weeks, 1996). The term "undocumented migrant workers" used in this study is based on immigration laws and the ILO's definition on migrant workers as: persons who have entered the country of which they are not nationals without passing through normal immigration procedures, and those who entered legally but violated the conditions of entry such as overstaying the visa. They are also engaged or have been engaged in remunerated activities in the host country. Migrants with a valid visa, but working without permission, are not

included in this definition. Therefore, this study mainly refers to an undocumented status based on the immigration law rather than the labour law.

2.3 Migrant Workers in Thailand: Profile and Measures

Factors such as, high mobility and ineffective measures to manage migrant workers contribute to diverse the estimated numbers of undocumented migrant workers. In September 2000, Thailand's Immigration Office estimated that there are all together about 2 million migrant workers throughout the country (Thai Rat Newspaper, 20 November 2000), which is much different from the total estimated 500,000 migrant workers in 1999 by the Labour Department, Ministry of Labour and Social Welfare (Chantavanich et al, 1999). However, among the estimated 2 million migrant workers, one million are from Myanmar (Thai Rat Newspaper, 20 November 2000), which is equal to the estimated one million of migrant workers from Myanmar in 1997 by Mahidol University (Archavanitkul, 1998). These different estimations may depend on the purpose and the method used by each department. Further studies on this estimation are needed in order to obtain more reliable data.

Studies from different years show that the majority of migrant workers in Thailand (about 50-85%), whether documented or undocumented are from Myanmar. Much smaller numbers are from Cambodia, the rest are from Laos, China and South Asia respectively (Chantavanich et al, 1999, Thai Rath Newspaper, 20 November 2000). Almost all of the undocumented migrant workers enter Thailand without any recruiting system nor any legitimate process. This on-going clandestine movement urged the Government of Thailand to take actions as it might cause insecurity or

instability in the nation and the fear that migrant workers will turn into permanent residents as well as problems on public health and unemployment of Thai people. Whereas, attempts for undocumented migration is likely to continue as long as there are significant differences in both countries' economic and political situation and as long as jobs are available in the host country (Chintayananda, Risser & Chantavanich, 1997 and Hubbell et al, 1991). Enforcement of laws for entering the country can only delay their success for migration, but cannot stop these migrant workers from moving. To improve management of their flow and existence requires a more pragmatic approach.

2.3.1 Registration to be Documented Workers

The Thai government tried means to better regulate the clandestine migrant labour force by amnesty and issuing work permits to these migrant workers. A study by Chintayananda, Risser & Chantavanich (1997) showed that the government's trial failed twice, in 1992 and 1994 due to the high cost for an annual work permit and bail fees (6,000 Baht in 1992, and 5,000 Baht in 1994). Another reason was the inefficiency in work permit card distribution, as some took six months to one year to distribute.

Since September 1996, the Cabinet had issued directives for the registration, which provided work permits for a maximum two-year period only to migrant workers from Myanmar, Laos and Cambodia, who were working in some specific provinces. Only some work categories were allowed such as construction, fisheries, agriculture, domestic worker and manufacturing (Chintayananda, Risser & Chantavanich, 1997). The number of work categories and the number of provinces allowed for registration have been changed according to each Cabinet resolution as shown in table 2.1. Total

numbers of migrant workers granted work permits have been varied from 303,808 to 158,253 and to 106,684 in 1996, 1998, and 1999-2000 respectively. The annual costs of registrations have been down and up from 5,000 baht in 1994 to 2,500 baht in 1996, and to 2,700 baht in 1998 with an additional 500-1200 baht required for purchasing a health insurance in most provinces (Caouette, Archvanitkul and Pyne, 2000). The total registration cost including health insurance and medical examination has been increased to 4,450 baht in 2001 (see table 2.1).

The economic downturn of Thailand at the end of 1997 caused a large number of Thai workers became unemployed. To bring jobs back to Thai workers, migrant workers were promptly deported from major urban areas. However, these cheap labour jobs have been abandoned by Thai workers. Private business affected by this policy then complained to the government about their difficulties to find replacement by Thai nationals, causing limit number of migrant workers allowed to register. These reducing numbers were actually lower than the demand of business owners as surveyed by the ARCM and the Labor Department. The Thai government claimed on remaining these numbers as for national security reason and its problems on management of the great number of workers. A health insurance card was required to be purchased by all migrants to solve problems on health cost to these migrant workers (Caouette, Archvanitkul and Pyne, 2000).

In August 2001, the cabinet resolution allowed broad range migrants from the same 3 neighboring countries who were residing in Thailand to register for a work permit in every province in all occupations including housekeeping and self-

employment, without limitation. This would provide a more accurate picture of the number of undocumented migrant workers in each location and their occupation (Raks Thai, 2002). Of total 559,541 workers registered this time, 447,093 were from Myanmar. Later years, 2002 and 2003, only the documented workers were allowed to renew their permit, no new migrant worker has been allowed to register.

A summary on the types of works permits, provinces permitted and the number of undocumented migrants who registered to become documented during 1996, 1998, 1999 and 2001 Cabinet Resolutions is presented in table 1.1.

Table 2.1: Number of Registered Illegal Migrants 1996, 1998, 1999 and 2001

Year	Types of Works Permit	No. of Provinces Permitted	No. of Migrants Registered	Country of Origin		
				Myanmar	Cambodia	Laos
CR in 1996	34	43	303,088	267,782 (87%)	26,983 (9%)	12,324 (4%)
CR in 1998	47	54	90,911	79,057 (87%)	10,593 (12%)	1,261 (1%)
CR in 1999	18	37	99,974	89,318 (89%)	9,492 (10%)	1,164 (1%)
CR in 2001	all	76 (all)	559,541	447,093 (79.9%)	54,459 (9.7%)	57,989 (10.4%)

(Based on Caouette, Archavanitkul & Pyne, 2000)

Note: CR - Cabinet Resolution

According to the Cabinet Resolution on a temporary scheme on the employment of foreign workers, all migrants were required to pass a medical check-up. A medical check-up included routine physical and mental examination as well as exam for alcoholism, tuberculosis, filariasis, malaria, syphilis, leprosy, and narcotic drug use (meth-amphethamine). Those who did not pass the exam would not be permitted to work and were required to leave the country (Chintayananda, Risser & Chantavanich, 1997).

Employers of these migrant workers had to follow the Thai Labour Code regarding social welfare provided to the worker, but many of them did not inform their workers of their rights (Chintayananda, Risser & Chantavanich, 1997). Thus, most of the registered workers were disadvantaged in terms of the social welfare they should receive. The daily wages they receive are usually lower than the minimum wage. The only main benefit these migrants receive is that they no longer had to fear of being arrested and could work without anxiety (HRDU & BWU, 2000).

2.3.2 Unregistered becomes Undocumented

Studies done by Chintayananda, Risser & Chantavanich (1997) and Nang Lao Liang Won (1999) found that other than being unaware of the registration, such as the lack of funds to pay the registration fee, was the usual reason for decision making of these migrant workers to not register. Other reasons were that there were options for registration in some groups like fisherman, many migrants did not know, or had little knowledge about the registration procedure or deadline, while other migrants were not facilitated by employers.

The migrant workers who failed to register and who were unable to register in due time each year for whatever reasons then, received the undocumented status. Failure to register pushes these migrant workers into pitfalls of being taken advantage from, doing hard jobs with low payment in return, without any protection from the labour law. They are housed in substandard conditions and exposed to many health risks from the dangerous job they perform without any health insurance. The migrant workers who failed medical check up during the registration process may not be aware of illness and may be at risk for spreading diseases without any control. Being undocumented maintains these migrants' fear and anxiety. Their illegibility limits them to use any health or public services, and makes them become more vulnerable.

2.4 Migrant Workers from Myanmar

Massive migration from Myanmar to Thailand has increased since the past decade resulting from the political force including the relocation policy, with gross human rights violations, by the Government of Myanmar (GOM). Over 100,000 people had to fled their homeland and become refugees residing in the refugee camps along Myanmar-Thailand border, and over one million are spread all over Thailand seeking for a job and a better life as migrant workers whether documented or undocumented.

2.5 Causes of Migration from Myanmar

The major underlining factors that encourage migration are pull, push and informal social networks. The importance of these factors has changed over time, which makes it difficult for any country to craft effective immigration policies and to manage migration flows. These three factors define migration pressure, which produces

migration only when individuals are pushed or pulled by a change in one of these factors (Martin & Widgren, 1996).

2.5.1 Pull Factors

Most migration stream begins inside the receiving countries and springs from economic pull factors. The Thai economical boom from the 1970s through the early 1990s has welcomed cheap labour from Myanmar, Laos and Cambodia mainly in construction, agriculture, fisheries, mining, and other industries that Thai laborers do not want to do (Chintayananda S., Risser G. and Chantavanich S., 1997). The high value of the Thai Baht over the Myanmar Kyat (in December 2000, 1 baht = 10.5 Kyat) makes that cheap wages are still attractive to the poor people in Myanmar and persuades more peers to come to work in Thailand (HDRU & BWU, 2000).

2.5.2 Push Factors

The excess supply of labour in countries has contributed to migration pressure worldwide. Low wages and unemployment in Myanmar are the push factors matching to the pull of jobs from Thailand. The other push factor is higher population growth of Myanmar (1.5% in 1999) than of Thailand (1% in 1999) while its economy is growing much slower (GDP/capita for Thailand = 5,456 US$ and 1,199 US$ for Myanmar, 1998).

Besides economic reasons, many people in Myanmar leave their country to escape various forms of violence from the government policy and from ongoing civil war among ethnic minority groups against the military rule. Amnesty International

(2000) reported that the Burmese military have continued to seize ethnic minority civilians for forced labour on infrastructure projects and for portering duties for the military in many states. Other violations such as rape, torture and general ill -treatment are common especially when they are unable to perform what the military require. Widely imposing resettlement or relocation programs by GOM in many areas, has forced many people, largely minority groups, to move from their homes. A study by HRDU & BWU (2000) presented various forms of taxes and fees demanded by the authorities with rampant corruption among government officials have forced people to leave their homes to search for jobs in Thailand.

The increasingly severe and systematic violations of human rights in Myanmar created a strong concern among international organizations especially the UN Commission on Human Rights (UNCHR), European Union (EU) and ILO. The International Labour Organisation adopted a resolution, against the Myanmar Government based on the military's widespread use of civilian forced labour. It decided that Myanmar could no longer attend ILO meetings or receive any technical assistance until it complied with the ILO Convention No. 29 on forced labour (Amnesty International, 2000). The reports of UNCHR indicate that the people in Myanmar are more vulnerable compared to other neighboring countries of Thailand such Laos and Cambodia.

2.5.3 Networks

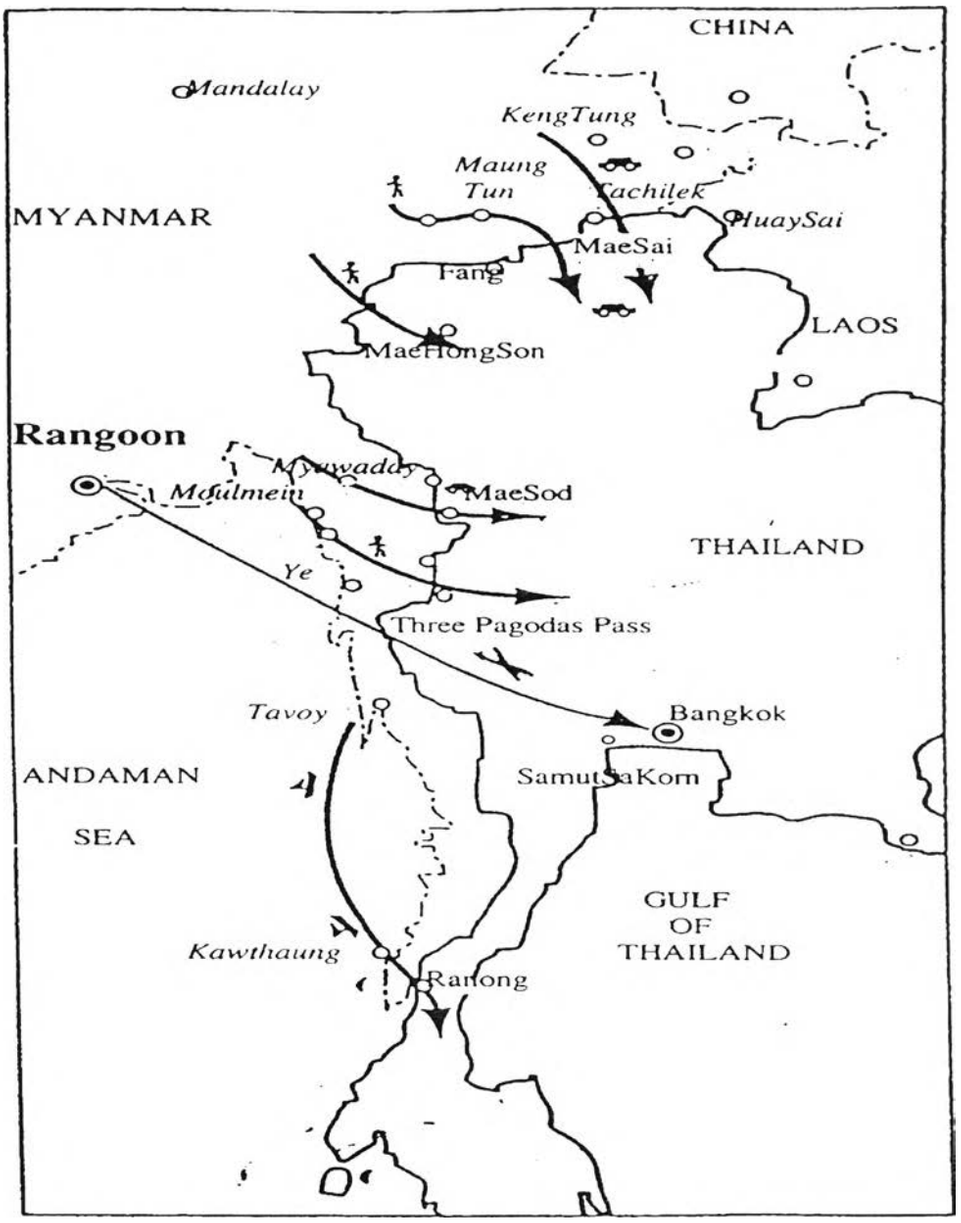
Networks are major linkages that turn potential into actual migration (Martin & Widgren, 1996). Most of these social linkages are among both kin and non-kin groups

such as friends and relatives of those migrants in Thailand who can provide credible information about jobs, travel and shelter. As migrants from Myanmar have continued to seek employment in Thailand for more than 3 decades, their mutual connection gradually strengthened. Labour contractors and brokers significantly shape labour migration from Myanmar to Thailand into trafficking, which generally is closely linked to illegal migration. The communication, transportation and human rights revolution of both Myanmar and Thailand have diminished the cultural gaps between both countries. Over 5,000 kilometers of Thailand's border, more than half of its length, is shared with Myanmar (2,532 kilometers), which may be one of the factors causing disproportionate high numbers of migrant workers from Myanmar in Thailand (HDRU & BWU, 2000). The improved transportation lowered the cost of travel, with more locations and entry points to access have enabled migrants to move across vast distances.

2.6 The Process of Migration from Myanmar to Thailand:

Most of the migrant workers from Myanmar enter clandestinely Thailand on surface across the country borders with assistance from brokers, friends, or their relatives. Many of them stop and find jobs at the Thai border area as their destination, others transit to other provinces all over the country (see figure 2.1). A significant number are taken directly to factories and work sites in Bangkok or the central region without a period of transit in the border province. The safest but most expensive way of migrant trafficking is by paying off corrupt Thai officials (HDRU &BWU, 2000). A great number of these migrant workers are concentrated in Bangkok and nearby provinces, such as Samutprakarn, Samutsakorn and Nontaburi (Archvanitkul, Jarusomboon & Warangrat, 1997).

Figure 2.1: Migration Route of Myanmar Migrant Workers to Thailand



Source: Situation of Labour Migration from Myanmar: Impact to Thailand and International Relation, Archavanitkul, 1998

There are four main border crossing-points from Myanmar to enter Thailand. They are Tachilek opposite to Mae Sai of north Thailand, Myawaddy opposite to Mae

Sod-west of Thailand, Three Pagoda Pass opposite Sungkhlaburi-west of Thailand and Kawthaung near Ranong-south of Thailand. Migrants come from all regions and districts of Myanmar. Their ethnicity include Shan, Karen, Mon, Tavoyan, Karenni, Burman, Arakan, Pa-O, Gorakha and Indian-Burmese. Among these ethnic groups, Shan migrants share similar language and culture to northern Thai people, therefore they can integrate into Thai society more easily, and have better opportunities for employment (HDRU & BWU, 2000).

2.7 Consequences of Irregular Migration from Myanmar to Thailand

The effects of migration on the host country are difficult to measure. There are no absolute labour shortages in Thailand. Migrant workers replace work positions in fields where Thai labours do not want to work. At the same time, migrant workers have reduced employment opportunities for Thai workers due to accepting jobs for lower wage and without benefits or security. Pinprateep (1999) said that without these migrant workers, business or industries such as construction, fishing, farming, could collapse as they rely on these cheap labour. The employment of these undocumented migrant workers for producing export products has become a crucial issue in international trade blockage including no consideration for loans from the International Monetary Fund and the World Bank. Remittances sent by these migrant workers to their home countries means a net loss to the Thai economy.

The negative impacts of migration are a concern to Thai officials and the public. Some Thai politicians, print media and vocal sections of the Thai public blame migrants for exacerbating social problems, such as rising crime rates, widespread

unemployment of Thai people, and spread of infectious diseases (Buruspat, 1997). These fuel an ill-feeling between Thai communities and Myanmar migrant workers, besides the negative perceptions based on the early Thai-Myanmar historical conflicts.

Crimes related to narcotic trafficking, murder, theft and other serious crimes committed by migrants, affect peace and security in Thailand. The Myanmar Embassy's seize, the Ratchburi hospital raid, and the Samutsakorn prison hostage in Thailand recently have given strong evidences of crimes and violence committed by Myanmar nationals on Thai soil. Controlling or investigating these problems is very difficult and has increased the burden on the Thai government's budget and manpower (Buruspat, 1997).

The Ministry of Public Health (MOPH) has reported that labour migration threatened to destabilize the normal scenario of communicable diseases along the Thai border and substantial parts of the country. Particularly some communicable diseases which have been under control in Thailand for some time such as malaria, filariasis, leprosy and encephalitis are patterns of diseases found among these migrant workers and are found among Thai people along border areas. Surveillance data from Tak province during 1997-1998 by Swaddiwudhipong (1999) show that there were about 40,000 Burmese patients with malaria each year, while in comparison there were about 25,000 Thai patients. Severe diarrhea and meningococcal infection were also more frequently reported among Burmese than Thais in this province including a very low proportion of Burmese migrant children who undergo full immunizing programs. Mahabhol, Pattarakulwanich & Rugpao (1999) reported that during 1997-1998, three

fourths of the foreigners seeking services of public health facilities all over Thailand were migrant workers. At least 50 million baht of the MOPH budget was spent annually on medical treatment of the illness of these migrant workers imitating the patterns of health complications in their country of origin. Without proper protective measures for preventable diseases, financial and human resources losses become crucial.

2.8 Consequences of Migration to Individual Migrant Myanmar Workers in Thailand

Remittances that migrant workers sent back to family members in their country can raise quality of life of their families and at the same time reward their country's economy (Weeks, 1996). In the mean time the undocumented migrant workers have to face a lot of problems themselves. Gardner and Blackburn (1996) suggested three aspects of the situation of migrant population to be focused for reproductive health care programs in developing countries. These aspects could be adopted to identify difficulties of migrant population from Myanmar in health programs. These 3 aspects are: social disruption, different cultural characteristics, and difficulties of access to public services.

- *Social Disruption.* Whatever reasons for moving, these migrants have been disrupted. They have left behind the support of traditional values, extended families, friends and a familiar way of life and must deal with new challenges. These migrants face many risks to their health especially stress, which effect directly their psychological health.

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- *Different Cultural Characteristics.* People who migrate often differ from the host people. The common different cultural characteristics between these migrants and local Thai people are language, race, ethnicity, religion, age distribution, and socioeconomic status. These differences are barriers for migrant workers to contact and request for assistance including adaptation to the local communities. It is important that programs know more about the migrant groups they are interested in, in order to tailor information and services to meet their specific needs.

- *Difficulties in Gaining Access.* People who move need health care but often lack access to services. Illegal status makes them ineligible for health care benefits, unable to obtain information easily, and uncertain where to turn. Fear of being arrested for illegal stay, are other concerns that keep them from seeking aid for their problems. Frequent movements make it difficult for migrant workers to complete their medical treatment. Discrimination by health providers often obstructs migrant workers' decision to use services as well. Not only health services, education services, and infrastructures are limited for migrants especially for undocumented migrants. Despite the public services available, many undocumented migrant workers are more likely to have less knowledge of availability of services, or access to services (Guest, 1998). Their hidden nature causes them to be hard to reach and seriously undermines their health status and quality of life (NORA, 1995).

Besides these three common aspects in a general migration situation, another aspect that undocumented migrant workers commonly face is "exploitation or deception".

- *Exploitation or Deception.* Migrant workers including children and female workers are often exploited and violated with non-payment or low wages and excessive hours of work, sometimes 18-20 hours per day, including no formal rest period for domestic workers. Some women workers are sexual assaulted by employers, security guards, or colleagues. They become victim of stress and social stigma. Being afraid of loosing their job make them reluctant to take matters to Thai law enforcement (Caouette, Archavanitkul & Pyne, 2000 and HDRU & BWU, 2000). Their usual jobs are hazardous, unsafe, and under poor conditions (Kols, 1983). Their children born in Thailand are without citizenship or nationality and without fundamental education (Pinprateep, 1999).

These four aspects: social disruption, different cultural characteristics, difficulties in gaining access and exploitation contribute to high vulnerability among migrant workers. These migrants have been exposed to a series of stress. Social and psychological problems frequently appear during adapting to a new culture, which may lead to poor health and problems in the family and at work. The most extreme situation is that of undocumented migrants, who have no access to any preventive or curative services, apart from emergency care.

2.9 Quality of life of Myanmar Migrant Workers in Thailand

The constitution of World Health Organization (WHO) defines health as "A state of complete physical, mental, and social well-being not merely the absence of disease or infirmity ". It follows that the measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of well-being and this can be assessed by measuring the quality of life. WHO has defined Quality of Life into a subjective evaluation as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of the environment (WHO, 1997, p.1).

In the cultural, social and environmental context of Thailand, reviewed literature provides four prominent domains in Quality of Life of the migrant workers from Myanmar on physical, psychological, social, environmental as follows;

2.9.1 Physical Health Problems

Factors contributing to increased communicable disease morbidity and mortality among migrants and local communities include; different microbial ecology makes migrant workers with low immunity expose to new agents and may get sick from disease easily; crowded living of migrant worker communities increases opportunities for disease transmission; and breakdown of access to the existing health infrastructure reduces disease control and treatment capabilities (Gellert, 1993).

Serious health problems perceived by migrants from Myanmar in Thailand from the study by Caouette, Archavanitkul and Pyne (2000) were malaria, work injuries, diarrhea, skin rashes and depression. Epidemic surveillance results from Ranong, Tak and Samutsakorn provinces rank common diseases among migrant workers as Malaria, diarrhea, filariasis and AIDS (Wongcharoenyong, 1999, Swaddiwudhipong, 1999 and Report of Samutsakorn Public Health Office, 1999). Deaths among family members were often reported in the study of Caouette, Archavanitkul and Pyne (2000) as a result of birth, malaria, work place injuries, and unknown causes of child fatalities.

Malaria transmission along Thailand-Myanmar border area is recognized as very serious. By migration passing through this border, low immunity migrants are vulnerable to malaria and may carry it inside Thailand. Malaria is the leading disease found among Myanmar migrants workers in border provinces such as in Ranong, Tak and even in Samutsakorn province, which is next to Bangkok (Wongcharoenyong, 1999, Swaddiwudhipong, 1999 and Report of Samutsakorn Public Health Office, 1999). The cause of high incidence of malaria in Samutsakorn needs further study. Caouette, Archavanitkul & Pyne (2000) concluded that high incidence of malaria mortality seems to be a result of lack of understanding of signs and dangers of the illness and need for proper treatment as well as inability to access available services.

HIV/AIDS prevalence can often be attributed to population mobility. Locations with large numbers of migrants, such as border towns often experience higher HIV/AIDS prevalence rates than those areas with smaller migratory population. Surveillance data of communicable diseases in Ranong-border province found that the

mortality rate of migrant workers caused by AIDS is highest compared to other diseases annually during 1995 to 1999 (Wongcharoenyong, 1999) from deaths recorded in hospitals. Whereas, HIV infection rates among Burmese sex workers in the monthly survey in Mae Sod of Tak province (about 90-103 workers) are reported to be as high as 21.5% in 1997 and 26.4% in 1998 (Swaddiwudhipong W., 1999). HIV prevalence rates among migrant workers enrolled for a medical check up for a work permit registration in ChiangRai border province were 4.01% (81 in 2,029) and 3.67% (5 in 136) in 1996 and 1997 respectively. Similar to the voluntary-confidential testing for HIV among migrant workers in 1998 in the same province showed a prevalence rate which was of 4.17% (2 in 48) and higher than general in Thai (2.14%) and Burmese (1.87%) residents as estimated by WHO (Supawitkul & Pattarakulwanich, 1999). Random screening during a check up for a work permit in 1999 registration in Samutsakorn province found that 2.7% of enrolling migrant workers were HIV positive (Report of Samutsakorn Public Health Office, 2000).

Reports by Mae Sod hospital of Tak province during the period 1995 to 1999 have shown that 69.9% (65 in 93 cases) of Burmese patients who tested positive for tuberculosis were early defaulters in the treatment course, while the default rate among Thai patients was only 27.3% (59 in 216 cases). The frequent mobility of migrant workers may be a significant reason. The high defaulter rate might increase the incidence of drug resistant strains and produce a serious public health problem in tuberculosis control in the future.

Data from Mae Sod hospital by Swaddiwuddhipong (1999) and the report of Mae Sod general hospital (2000) show that during 1997 and 2000, the number of abortions including unsafe abortion among Burmese (195, 252, 290 and 247 cases respectively from 1997 to 2000) is higher than among Thais (114, 175, 121 and 164 cases respectively from 1997 to 2000). Septic abortions, which commonly result from illegal abortions, were also much higher in Burmese than Thais. Its possible reasons could be lack of knowledge and inability to access family planning services.

Diarrhea and severe diarrhea are leading diseases among Burmese in Tak and Ranong provinces. Due to frequent movement, crowded living with poor sanitation influents spreading of the diseases. Cooking and eating behavior in the new working condition and environment may make migrant worker more vulnerable to diarrhea (Wongcharoenyong, 1999). Lack of knowledge and information on treatment and prevention of disease contribute to their vulnerability.

Migrant workers often complained about disturbing skin rashes due to poor water quality or limited access to water (Caouette, Archavanitkul & Pyne, 2000). Some severe skin allergies were found among migrant workers working for a long period under wet conditions such as a seafood-processing factory. Some migrants are allergic to gloves and boots, which they have to wear while working.

The study by Caouette, Archavanitkul & Pyne (2000) indicated that accidents, particularly from motorcycles and at work place were also one leading cause to death among migrant workers with significant higher incidences in men than in women. In

some types of work, migrants had to encounter work injuries nearly everyday and many had serious injuries as most workplaces do not have adequate safety provisions for their employees. In addition, hospital officials have noted that migrant workers are often injured from traffic collisions or other accidents. Migrants' lack of knowledge regarding traffic laws, driving behavior of Thai people, and Thai language put them at high risk of road accidents.

2.9.2 Psychological Health Problems

Migrants are exposed to a series of stress not commonly experienced by sedentary families; separation from family and friends, disruption of former networks and of social support, and the need to adapt to new cultural norms, roles and responsibilities. Social and psychological problems frequently appear during this adapting process, which may lead to poor health (Bollini & Harald, 1995).

Suffering from civil war, human abuses, and economic hardship push many migrant workers to flee from their home in Myanmar. They hope for a better life in Thailand with some income but their suffering may not be less than in Myanmar. Many of them are abused by employers, supervisors, and employment brokers. The psychological impact of the attitude of the police is great. Some women said there is no place that can be free from police harassment, which affects their life directly or indirectly. Living illegally and doing illegal work add to the fear of being arrested. They feel a constant fear and being frightening by both Burmese soldiers and Thai policemen. Due to the fact that these migrant workers are poor, are residents from a poor country, being aliens, and reside illegally, many of them are discriminated by local

Thai people (Nang Lao Liang Won, 1999). These discriminations affect the psychological well being of migrant workers.

The literature does not report studies conducted on mental problems among migrant workers in Thailand. There is only the study by Caouette, Archavanitkul and Pyne (1999) reporting that mental health is also a common health problem among Burmese migrant worker populations. The incidence of their experience with stress, depression and anxiety was high. In addition, three migrant workers committed suicide as reported by Samutsakorn Provincial Public Health Office in 1999. This could be one indication of mental problems among migrant workers.

Drug and alcohol abuse is often related to mental stress. Data from medical check ups for work permit registration for migrant workers found 0.7% of enrolling workers in ChiangRai province in 1998 were drug users (met-amphetamine) and 0.14% (28 cases) in Samutsakorn province in 1999 (Supawitkul & Pattarakulwanich, 1999 and Report of Samutsakorn Public Health Office, 2000). A study in Samutsakorn in 1998 by CARE Thailand/Raks Thai Foundation (1999) reported that drinking alcohol, playing cards and using drugs (orally taken) was said to be common among migrant workers. Its survey with 116 migrant workers found that 40.5% of the respondents used drugs with major use of marijuana, followed by codeine, amphetamine and heroin. This finding agrees with a similar study by the Asian Research Center for Migration (Chantavanich et al, 1999) conducted among migrant workers in Sangklaburi-border town and Ranong-border province that drug abuse is present in these migrant populations. In the same study, it is also stated that Burmese fisherman are known for

high alcohol consumption, which they attribute to their difficult life in Thailand often related to their illegal status.

Domestic violence is recognized to be attributed to mental health problems and was also reported in the study of Caouette, Archavanitkul & Pyne, (1999) to be high in migrant workers population in Thailand.

2.9.3 Reduced Social Relationships

Results from the studies by Caouette, Archavanitkul & Pyne (2000) and by Chantavanich et al. (1999) agree that migrant workers from Myanmar are typical young migrant population with majority of age between 21-30 year old. As most of younger and older members in their families were left in Myanmar, their family relationships are disrupted. Many left their spouse behind and many re-married and have new families in Thailand. Many migrant workers feel that there is no strong sense of community, which make them ignore the other migrants' problems, especially problems regarding domestic violence.

Frequent movement causes migrants to be seen as "newcomers" and creates difficulties in building relationships based on trust. Less leisure time may lead to less opportunity to contact or join with other neighboring migrants (Arj-am & Chical, 1993). Therefore, many migrant workers coming from the same area in Myanmar were found to be living in the same compound (CARE Thailand/Raks Thai Foundation, 1999). A study by Chantavanich et al (1999) showed that many migrants were living in Sangklaburi and Ranong for several years and were concentrated in their own

communities. Most migrants disrupted from family due to difficulties in getting or sending news as poor infrastructure at their hometown. Other problems migrants often face are access to information or assistance from Thai people, including difficulties in seeking health services especially due to their low proficiency in Thai language.

2.9.4 Poor Environmental Conditions

2.9.4 a. Physical Environment

Although the majority of the Thai population living in the same areas have access to safe water and electricity, migrant worker communities are often isolated and segregated with limited access to these services (Caouette, Archavanitkul & Pyne, 2000). A survey by Samutsakorn Public Health Office in 2000 reported that the local community environment in which migrant workers reside changed. There has been an increase of garbage, poor sanitation and noisier environment.

2.9.4 b. Living Conditions

From the studies of Nang Lao Liang Won (1999) and Caouette, Archavanitkul & Pyne (2000), the living conditions of migrant workers usually depends on the nature of their occupation. Factory workers mostly stay in a small apartment or in a big hall with an overcrowded condition and poor ventilation. Domestic workers often sleep and work at the same place, isolated from the outside world. These migrant women are more vulnerable to sexual abuse by men in the household. Shelters of

construction workers usually are very unstable and are cramped without privacy. They often stay in dark makeshift rooms in buildings under construction or in shanties made of leftover zinc sheets, plywood or cardboard sheets on their construction sites, with no ventilation, infested with rats, and vulnerable to fire hazard.

2.9.4 c. Physical Safety and Security

Undocumented migrant workers can be arrested under the Thai Immigration Act for illegal entry, which is often punished by detention, or fines, or both. Although documented, migrant workers could also be arrested because of not holding their original work permit, which most of their employers keep with them. These workers face psychological suffering from arrest without speaking or understanding Thai language. Nang Lao Liang Won (1999) and Burma Human Rights Yearbook 1999-2000 (2000) reported that a lot of migrant workers, particularly women and girls, are extorted, abducted and trafficked by Thai policemen. Most of migrant workers experience deception and exploitation by employers or brokers. Stories of employers treating them like slaves, cheating on their wages, or failing to fulfill the initial agreement, asking police to arrest workers to avoid payment, brokers taking away their wages without consent were prevalent among migrant population.

2.9.4 d. Working Condition

Migrant workers from Myanmar often endure unsafe working

conditions and long hours of work for relatively low pay. Most of them receive daily wages less than the Thai minimum wage services (Caouette, Archavanitkul & Pyne, 2000). Fear of losing job makes them hard to refuse overtime work even when they are too exhausted, unless they are serious ill. As stated by Nang Lao Liang Won (1999), most of the domestic workers have to be on call 24 hours a day, and many of them are treated inhumanely.

2.9.4 e. Access to Health and Social Services:

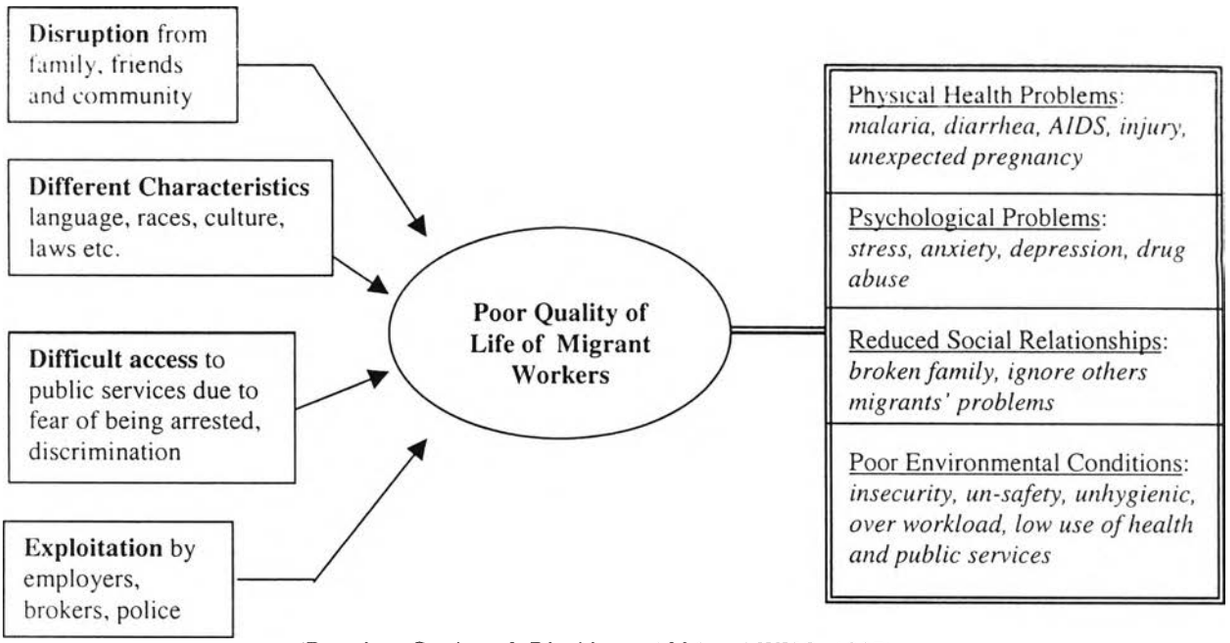
The study of Caouette, Archavanitkul & Pyne (2000) found that illegal status, financial saving, and the inability to communicate in Thai language were the main factors determining their health seeking decisions. The majority first sought their health care needs by purchasing drugs or seeking traditional health methods or caregivers. Many perceived that assistance from their employers was the only means to access health providers whether public or private. Public health services were choices for emergency and birth delivery. Private health services were preferred as their proximity and anonymous nature even they were more expensive. Many migrants avoid seeking health services until one's health deteriorated or turn into a life-threatening situation.

Although provision of medical care may exist, access by migrants is limited due to restrictive policies and practices. Verghis, (2000) presented an example that notification to infectious diseases and deportation of those who suffer from infectious

diseases deter migrant from using the services even many diseases are easily treatable. Disclosing themselves for facing diseases may result them losing their job. In several instances employers have directly restricted their workers in accessing health care. Nang Lao Liang Won (1999) also added that lack of access to health education, and primary health facilities can lead to undesirable consequences such as being treated by the person who do not have proper medical training.

Framework in figure 2.2 provides a summary on the causes affecting Quality of Life of migrant workers and its consequences. Disruption of family, community and society; different in characteristics such language, races, religious, culture, and economic status; difficulties of access to public services; and being exploited by employers, brokers or policemen have reduced Quality of Life of migrant workers from Myanmar residing in Thailand in general. These affect migrant workers environmental conditions such as insecurity and risk of being arrested, dangerous workplaces, unhygienic, unstable living places; disrupted social relationships such as difficulties to contact home; psychological problems such as stress, anxiety, depression, drug abuse; and physical health problems such as various communicable diseases and injuries.

Figure 2.2: Causes and Consequences of Poor Quality of Life of Migrant Workers



(Based on Gardner & Blackburn, 1996 and WHO, 1997)

2.10 Responses of the Thai Government to the Needs of Migrant Workers

The problems of these migrant workers are diverse and complex. They are too complicated to address with one single approach. Since 1992, Thailand's policies on the management of migrant workers has been based on national security and capitalist concerns. The government has fulfilled labor shortage in some business sectors by allowing a limited number of registered workers. It rules these migrants by controlling, but not be protecting. The policies seem to recognize these migrants as disposable resources rather than productive resources of the country.

A protective response from Thai Government to these migrants is fortunately practiced in health issues. The Thai Government is concerned about illegal cross-border migration as one of its major problems, particularly problems on re-emerging diseases

that were eradicated or under control in Thailand. Although facing a heavy burden on country's resources, both health facilities and expenses, the government still provides appropriate and necessary health services, and supports undocumented migrants based on humanitarian ground. On the other hand, it needs to control transmission of diseases following this migration.

In order to reduce the burden on public health funds, the Thai government adopted a public health measure for migrant workers to purchase an annual health card or the social security scheme as Thai workers do. The effectiveness of this policy is limited because many workers are not well informed on their rights and many employers are not helpful. According to a study by Caouette, Archavanitkul & Pyne (2000), employers often keep migrant workers' health cards to prevent them from running off or changing employers.

The health situation seems to be worse among undocumented migrant workers who are not illegible to health cards. Their access to health services is even harder and limited or obstructed by several problems. Fear of being discriminated by health care providers or of being arrested by policeman are main concerns that keeps many undocumented migrant workers from seeking aid for a serious health problem.

In some provinces the Provincial Public Health Office has collaborated with NGOs in setting up clinics exclusively for migrant workers or implementing special outreach programs to serve their communities and families, especially for HIV/AIDS prevention in vulnerable populations. Despite diverse affords, there are many obstacles,

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thus problems still exist. Moreover, health officials at various levels often do not fully embrace these policies and there is still distinction between Thai and non-Thai patients (Caouette, Archavanitkul & Pyne, 2000).

2.11 Alternative Intervention Approaches to Improve Quality of Life of Migrant Workers

In order to address the problems in any target migrant population, a number of activities have been reviewed as possible interventions. Research shows that interventions that include various approaches are more likely to have an effect on the target population than those that consist of only a single approach (McKenzie & Smeltzer, 1997). Importance is that the approaches need to fit the goals and objectives of the target population in a program in order to reach desired outcomes. The efficiency, effectiveness, and success or failure of intervention used in dealing with migrant populations can be reviewed by networking with concerned organizations and by reviewing the literature. Approaches could be categorized into 5 groups as follows:

2.11.1 Educational activities

2.11.2 Regulatory activities

2.11.3 Community advocacy activities

2.11.4 Communication activities

2.11.5 Health status evaluation activities

2.11.6 Social intervention activities

2.11.1 Educational Activities:

Methods used include discussion, group work, audiovisual materials, and written materials. One most common target group for education activities to migrant

populations is the peer group. Peer education is often effective in reaching a target group. However, mobile populations present particular constraints such as the turnover in their composition creating certain constraints to the establishment of peer outreach programs. Within some groups, work fully occupies their time and participation in a peer outreach program is rarely possible (Panitchpakdi, 1999).

Topics selected for training or education are also important. A project on migrant population run by CARE-Cambodia learned that focus on one special illness or disease in isolation is not appropriate (Panitchpakdi, 1999). There are so many other issues such as labour rights, poverty and general health that should be addressed with target groups. Nang Lao Liang Won (1999) suggested that education can give necessary and practical information to migrant workers, such as survival skills in Thailand, health information, laws and rights information. So they will be able to control their lives in a proper way.

2.11.2 Regulatory Activities

Regulatory activities exist for the protection of the community and of individual rights. But, policies and laws imposed by the Government of Thailand, whether on immigration or labor issues, have been aimed only to control migrant workers and failed to protect them. Consequently, undocumented migrant workers are most neglected and victims of discrimination and exploitation. These laws and policies need to be adjusted by the policy makers involved.

Health Policy

In 2000, the Ranong Provincial Public Health Office under the governor's permission allowed all migrant workers in the province to apply a health card at 500 baht per person per year, regardless their illegal status, in an effort to reduce the burden on its health budget. These card-holders would be also excepted from being arrested in the adjacent of Ranong province to increase their access to health care. However, none of the undocumented workers bought this card. Economic constraints may influence their perception on health insurance to be unnecessary. Another reason may be they are not well informed about the card and its benefit.

A comparative study of health policies for migrants in seven countries (2 in North America and 4 in Europe) by Bollini (1993) has shown that the countries which have acknowledged the health problems posed by migrant groups, and have actively tried to provide alternative solutions, have succeeded in removing most of obstacles concerning access to health care of migrants. Significantly, Sweden is the only country in the study that in accordance with the law provides a routine interpreter service during medical encounters.

Labor Laws

In the study of Sriwattananukulkij (1999) on Quality of Working Life of Thai migrant workers in Japan mentioned that the Japanese Government has tried to solve the problem regarding undocumented migrant workers by changing undocumented migrant worker-status into trainee-status. In this way, it can avoid confrontation with the Japanese Labor Union, who are against the acceptance of foreign workers, as it may

increase bargaining power of employers over local labor. Its government also applied 'Fairness Principle' following the international law by issuing a 'Labor Standard Law' to protect every person who works in its country even if they enter the country illegally. It concerns violation of immigration law, not labor law. This can protect migrant workers from being exploited by employers as the exploited workers can appeal to the Labor Department and the Labor Department cannot use this illegal entry reason to accuse undocumented workers and deport them.

However, regulatory activities are mandatory, which commonly face pro and con responses toward actions. Therefore, good judgement with respect to all stakeholders is necessary before implementation.

2.11.3 Community Advocacy Activities

Different from regulatory activities, community advocacy activities aim to influence social change. It is the process in which the people in the community become involved in the institutions and decisions that will have an impact on their lives. Techniques often used in trying to influence these decision-makers are lobbying and campaigning. Panitchpakdi (1999) and Nang Lao Liang Won (1999) suggest advocacy as a key aspect of action that needs to be directed towards both governments and the general public. Some of these aspects include: access to health information and medical treatment; protection of basic human rights of migrant workers to reduce their vulnerability to violations, violence, and exploitation; voluntary blood testing and confidentiality of results.

Moreover, these should include activities or projects to inform and influence the international community, governments and peoples so that they can better understand the problems and needs of migrant workers and get migrant workers themselves to voice their concerns.

2.11.4 Communication Activities

The most visible forms of communication activities are those in the mass media, which include daily newspapers, television, radio. Other communication activities are billboards, leaflet, brochures, posters, and newsletters, video and interpersonal communication. Various health messages in Burmese and some ethnic languages have been provided by NGOs and government through brochures, posters, and video but need to be adjusted to target specific migrant worker group.

Hotline services

Telephone information services including medical information and consultation are the main strategy provided by many Japanese NGOs assisting foreign migrant workers living in Japan. In Thailand, Hotline is often used in counseling and is good for confidentiality and for constraints in distance. Skills and ability to these services need to be established before providing this kind of service.

Radio Program

Radio is beneficial in reaching a great number of target populations and has been used to disseminated information and health knowledge including bridging migrant networks. An NGO serving migrant workers in ChiangMai province has been

able to broadcast a radio program for some Burmese ethnic migrants but its frequency wave is still difficult to access.

2.11.5 Health Status Evaluation Activities

These activities are aimed not only to reduce transmission of diseases to and from migrant populations but also make them more aware of their health status. They have involved the recognition of their health risk, self-screenings, clinical screenings, and health checkups. Their settings include health care facilities and mobile units.

Clinical Service

Clinical service is particularly necessary, as a mobile population does not have immediate access to regular health services due to lack of information, regular movement, and language difficulties (Panitchpakdi, 1999). Establishment of a clinic is difficult and sustainability is questionable, such as the clinic run by World Vision Foundation-Thailand in Ranong, is not able to sustain under the Thai Public Health regulation (Chantavanich et al., 1999). The Thai government has also initiated programs in some provinces to provide family planning services and promote disease prevention and environmental sanitation. Especially, routine checkups for venereal diseases for sex workers, which also include migrant sex workers. However, these public health programs are unable to reach those who live in hiding for fear of arrest.

A mobile clinic is an alternative for clinical outreach program, which can reduce difficulties in access to health services of undocumented migrant workers, but still face other management constraints as well as obstacles from Thai laws.

2.11.6 Social Intervention Activities

The social intervention activities that can support undocumented migrant workers to improve their Quality of Life include enabling support programs to increase their self-esteem, increasing self-confidence, and protect their rights, so that migrant workers will be able to increase control over their lives (Nang Lao Liang Won, 1999). These activities should also aim to enable migrants to get easier access to services available, and to use services.

Community Support Groups

The importance of community support is that people join together to share experiences and support the others. Some community-meeting places like temples and churches are the places where ethnic minorities from Myanmar gather and have some activities in Thailand. As suggested by Nang Lao Liang Won (1999), establishing trust by developing a good relationship with migrants and participating in their activities are needed before implementing programs with these groups. Community support can create a bridge between existing local communities and migrant populations. Therefore, they will have a sense of belonging, feel less lonely and less isolated. This may include projects that target local communities on how to prepare to work and live in harmony with the host population.

In Ranong, a migrant community development committee has been formed with technical support of an NGO to provide continuity and sustainability of community intervention and cohesion. It's aimed to promote and sustain health, education, and sociocultural conditions of communities of migrants from Myanmar residing in Ranong

(World Vision Foundation of Thailand's Annual Report, 1999). Their success may be because many Thai and Burmese people living along Koh Thaung-Ranong border area are relatives for generations, local communities in Thailand are familiar with migrants. In addition, a number of migrant workers have been staying in Ranong almost permanently allowing an opportunity to initiate steering committee to support other migrants. More strategies are needed to initiate these activities in other areas.

Community support may include social services to help migrant workers with their communication problems such as facilitate access to health services by using interpreters and social workers. Migrant workers could send or get news only through people whom they really know, and trust, including sending remuneration home through this support system.

Social Activities

Bringing together people who may be confronting similar problems for the purpose of purely social interaction not related to the problem can indirectly help them deal with the problem (McKenzie & Smeltzer, 1997). These activities are not new to most of migrants, as they are often organized for the community they belong to. The activities are mostly for family crises, and social functions such as wedding ceremonies, funerals etc. (Nang Lao Liang Won, 1999). A bridge between existing communities and migrant communities will bring the former give initial assistance to the latter to set up their activities and services. It helps migrants to keep contact with their own people, and make connection for their working opportunity as well.

Self-help group

Even though self-help group is also formed by people confronting similar problems, the purpose of this social interaction is to directly help them deal with the problem by themselves. A self-help group is one of the meaningful and effective ways to help migrant workers to promote their confidence to overcome their problems, have a sense of solidarity, and have at least moral support in Thailand. However, it is recognized that in some workplaces, workers are barely able to look after themselves due to lack of time and money (Nang Lao Liang Won, 1999).

Social Networks

When people are networking, they are said to be looking for relationships that would be useful in helping them with their concerns, such as problem solving, program development, resource identification (McKenzie & Smeltzer, 1997). Migrating to another country probably depends on social networks that link migrant workers to that country (Moretti, 1999). This social network links migrants from Myanmar to enter Thailand day to day as mentioned earlier that a lot of migrant workers came from the same area in Myanmar are concentrated in the same community and location in Thailand (CARE Thailand/Raks Thai Foundation, 1999 and Chantavanich et. al, 1999).

Social networks and social supports are considered to be key intervening variables in physical and mental health (Sarason, Sarason, & Pierce, 1990). A strong relationship was evident between social support and psychological well-being for women in a study conducted by Wayment (1995). Another study conducted among Mexican undocumented migrant women in San Francisco indicated that these women dealt with the challenges of work by informally collectivizing and sharing information

through social networks (Hondagneu-Sotelo, 1994). In a dynamic urban context, communities are better conceptualized as informal networks of ties. These network structures may help to protect, or conversely, expose members to reproductive risk behavior (Bond, 1999).

Social networks can both strengthen and weaken over time, can change differentially for different segments of the migrant community, and therefore can have disparate effects on migrant incorporation (Hagan, 1998).

2.12 Solutions to Contribute to Improve Quality of Life of Migrant Workers

One success example is the HIV/AIDS prevention and care program for migrant workers conducted in ChiangRai by Provincial Health Office and Norwegian Church Aid (Koedkan et al., 1999). The strategy for their health service model with activities is the *partnership* of migrant workers, employers and hospital. Steps of this strategy include; participate planning; volunteer training; service provision and a referral system in place. Their main interventions are; workplace based, outreach service, and a referral system.

Dealing with a mobile population is not easy by nature and could be even harder with undocumented migrant workers. In order to address their problems, all the main causes of problems should be considered. Combination strategies should be conducted if sufficient sources are available. Involving of all stakeholders that can either facilitate the project in reaching its target population is commonly recommend but hardly possible. Such groups include employers, locations, immigration police, and local government officials.

An appropriate intervention for any targeted migrant worker population depends on their situation and needs. Before setting up any project it is necessary for the project planner to have identified migrants to take in part in every step of the planning process. It is an advantage to identify and mobilize the existing social networks and support group in the targeted population to build their capability to take care of themselves with less support from outsiders.

2.13 Conclusion:

This chapter has reviewed the situation of international labor migration and vulnerability of migrant workers including the situation of migrant workers in Thailand. The Thai government has policies to regulate the clandestine migrant workers by issuing work permits under a limited number in some occupations. Ones failed to register this temporary work permit, migrants become undocumented workers and are illegible to stay in Thailand.

Migrant workers from Myanmar are a significant concern as they share at least half of the estimated 2 million migrant workers all over Thailand. Causes and effects of this migration have been reviewed. Major pull-factors that encourage their migration were the 1970s economical boom in Thailand and the high value of the Thai currency over Myanmar currency that makes low wages become attractive to the low-income people in Myanmar, which is persuading more peers to work in Thailand. Low wages and unemployment in their country, with severe and systematic human rights violations by the Government of Myanmar are the push factors matching to the pull of jobs from Thailand. The strengthened network and improved transportation enabled migrants to

migrate across the country. The large number of these migrant workers to Thailand is a concern for both the public and the Thai government for their effects to Thailand's social, economic, politic, environmental and health problems.

There are a lot of problems that these migrant workers are facing, but less concerned by public or government policies. Being an undocumented migrant worker is not a crime. These workers are productive resources who also make profit for the host country, equal to undocumented Thai migrants working oversea. Their rights and dignity should be respected, and their problems should be assisted.

Factors affecting Quality of Life of migrant workers are categorized into 4 main factors as; *disruption* of family, community and society; *different in characteristics* such language, races, ethnicity, religious, culture and economic status; *difficulties in access to public services*; and *being exploited* by employers, employment brokers or policemen. These factors have reduced Quality of Life of migrant workers from Myanmar in Thailand's context, while adapting to a new culture. They affect migrant workers in terms of *environmental* conditions such an insecure life and being arrested, dangerous workplace, unhygienic, unstable living places; disrupted *social relationships* such difficult to contact home; *psychological problems* such as depression, anxiety; and *physical health* problems such as various communicable diseases and injuries.

The migrant workers are human beings whose rights and dignity are being abused; their suffering could be alleviated if there is some understanding and sympathy from the government and the people.

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