CHAPTER 3

Proposal: Assessment of reproductive health perspectives, concerns and realities among female migrants from Myanmar in Thailand

3.1. Introduction

The influx of migrants from Myanmar into Thailand is one example of the ever-increasing number of females migrating throughout Asia and the world who often find themselves in isolated and abusive environments (Battistella, 1996). The reproductive health needs of this growing population of female migrants have gone largely unnoticed by governments, non-government bodies and researchers. However, an awareness is emerging of this neglect which highlights the reproductive health concerns and needs of female migrants (Population Reports, 1996).

The aim of this study is to describe the reproductive health perspectives, concerns and realities of female migrants from Myanmar in Thailand in the broader context of their lives. The results of this research will be used to highlight the reproductive health needs of female migrants from Myanmar in Thailand. In addition, the findings will provide a background for policy makers, service providers and

researchers to consider in developing appropriate policies, interventions and identifying areas in need of further investigation.

Government officials in Thailand are increasingly being asked to address the presence and human rights of undocumented migrant workers both sent from and brought into their country.[13] Migrants are often an integral part of communities where they reside and therefore should be included in health initiatives, especially related to communicable illnesses. In addition, growing migrant populations have health needs that are currently impacting health systems, particularly in the areas where they reside in large numbers. Understanding how migrant populations address their health needs could facilitate more effective support to health systems and their operations.

Non-governmental organizations have a critical role to play in raising the needs of hidden populations and sensitive issues with governments and other international and national bodies (Farrington and Lewis, 1993). This research will provide non-governmental organizations with information and support in their efforts to identify the reproductive health needs of migrant populations, propose interventions and build a consensus among themselves and other international bodies. With this knowledge base and consensus governments can be approached and challenged to consider migrant

populations, their reproductive health needs and appropriate strategies for addressing them.

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[13] Numerous conferences and consultations have been held with the Royal Thai Government and other governments in the region to address the realities of migrant workers moving into, out from and through their countries. The health status of migrants, their vulnerabilities and the impact on host country populations and health systems have been discussed in many of these forums.

This research proposal was developed further by a team of researchers, received funding and was implemented from January to June 1998. The proposal presented here is the input of one researcher to this process and was not the actual proposal submitted for funding on behalf of the team project. However, footnotes will be made throughout this version of the proposal to note fundamental changes made by the team in the final funded project.

3.2. Background

Over one million migrants from Myanmar currently reside in Thailand (Archavanitkul & Koetsawang, 1997a; Human Rights Watch, 1997). They are an ethnically diverse population coming from all over Myanmar and speaking many different languages, often lacking a common language among themselves. Migrants from Myanmar are culturally and linguistically distinct from their Thai neighbors. They typically reside in Thailand illegally and take low paying jobs that Thai nationals do not fill. The migrants from Myanmar in Thailand receive little or no health care services and little attention has been given to their reproductive health needs. However, this is changing as the HIV infection rates among migrants from Myanmar are proving to be some of the highest in the region (Porter, 1995).

The ability for girls and women to address their own reproductive health concerns are directly influenced by the broader context of their lives and the ability to which they are able to exercise their basic human rights (Mann & Gruskin, 1995; Sen,

Germain, & Chen, 1994). Often female migrants from Myanmar are unable to access or choose safe reproductive health care and report living in extremely abusive environments with high incidences of drug use, sexual harassment and physical and sexual violence. Such surroundings identify them as a 'risk group' with high rates of HIV/AIDS infection found among them. Female migrants from Myanmar have received little or no information or services given their isolated and often illegal status. The high rates of HIV/AIDS infection highlight the problems surrounding their health in general and reproductive health in particular. Until there is this basic understanding, of the lives of female migrants from Myanmar in Thailand, interventions to address HIV/AIDS or any other specific reproductive health issue, will have a limited impact on their lives.

Female migrants from Myanmar face more difficulties as they typically work in unrecognized labor sectors (such as domestic service, prostitution or as mothers or housewives), are paid less than men and face different concerns and needs (Archavanitkul & Koetsawang, 1997b). They have little or no opportunities to receive health education or services, and their reproductive health care has largely gone unaddressed. In addition, many girls and women from Myanmar come from rural or minority areas where reproductive health education or services are under-developed or non-existent (Smith, 1996). Consequently, female migrants from Myanmar are further limited in their ability to draw on their own or their community's knowledge base in addressing their reproductive health concerns.

There is extremely limited information available on the lives of female migrants from Myanmar in Thailand and their reproductive health concerns, consequently, interventions on their behalf often inappropriate, ineffective and even detrimental (Beyrer, 1998). The available gender specific research on reproductive health among girls and women from Myanmar has been limited to either that undertaken in Myanmar itself or among female migrants from Myanmar involved in prostitution. Reproductive health research within Myanmar has begun to highlight the perspectives, concerns and realities faced by women of reproductive age (World Health Organization, 1997). However, a review of the literature coming out of Myanmar (published and unpublished) fails to document the impact of migration; the realities in many minority areas or take into account the entire reproductive health cycle of females from birth to death (Smith, 1996). The available research on sex workers from Myanmar in Thailand provides little insight into their reproductive health perspectives, though concerns of high rates of HIV/AIDS infection and non-consensual reproductive health interventions are reported (Archavanitkul & Koetsawang, 1997b; Pollock, 1996; Asia Watch, 1993; Pyne, 1992).

It is a critical time to provide the Thai government, international and non-governmental agencies with information about migrant workers, particularly women and to advocate on behalf of their realities and needs. In 1996, the Thai government officially acknowledged the presence of over 900,000 illegal migrants currently employed in 43 of the 76 provinces in Thailand in eight employment sectors (Chintayananda, Risser & Chantavanich, 1997). The official recognition of this growing population opened the door for discussion of migrant issues previously

refused. Legislation introduced in June 1996, required employers to register migrant workers from Myanmar, Cambodia and Laos with the provincial government. The number of migrant workers registered in 43 provinces by country of origin and by sector were calculated from an unpublished document, Labour Department, Ministry of Labour and Social Welfare and presented in Tables 1 and 2 below (Archavanitkul, Jarusomboon, & Warangrat, 1997).

Table 1 : Number of Illegal Migrant Workers Registered in 43 Provinces by Country of Origin (from 2 September to 29 November 1996)

Region	No. Of	Country of Origin				Fee in Baht
	Province	Burma	Laos	Cambodia	Total	
Bangkok	1	30,230	2,556	4,133	36,919	30,792,900
Periphery of Bangkok	5	41,225	1,862	2,141	45,228	37,370,800
Central	13	58,496	4,413	15,084	77,993	69,412,000
North	9	39,728	173	34	39,935	39,727,800
Northeast	2	977	206	141	1,324	1,321,500
South	13	76,023	1,876	3,213	81,112	76,313,600
Total	**43**	**246,679**	**11,086**	**24,746**	**282,511**	**254,938,600**

Table 2 : Number of Illegal Migrant Workers Registered in 43 Provinces by Sector (from 2 September to 29 November 1996)

Region	Total Num-ber	Agri-culture	Con-struc tion	Fishery & related	Min-ing	Trans-porta-tion	Manu-factur-ing	House maid
Bangkok	36,919	324	21,394	-	-	649	2,005	12,547
Periphery of Bangkok	45,228	4,543	17,585	15,388	-	918	3,484	3,319
Central	77,993	24,748	21,113	16,021	1,126	479	7,802	6,704
North	39,935	15,006	10,857	48	199	-	4,118	9,707
Northeast	1,324	213	742	23	-	-	113	233
South	81,112	32,875	21,667	18,555	147	458	4,811	2,599
Total	**282,511**	**77,700**	**93,358**	**50,035**	**1,472**	**2,504**	**22,333**	**35,109**
Percent	100	27.5	33.0	17.7	0.5	0.9	7.9	12.4

* Only water transportation business is allowed to hire illegal migrants.

Prior to this registration, all contacts with or assistance to illegal migrants was considered illegal and subject to fines and even imprisonment. Though the law remains, there is more flexibility for attempting to work with the migrant population in Thailand. Although the legislation to register migrants was limited to certain sectors of employment, only 43 of 76 provinces and implemented for only three months (September 1- November 30, 1996), it offered an opportunity to contact migrant communities and seek a deeper understanding of their lives and concerns. At the same time, increased attention to the ongoing trafficking of girls and women from Myanmar into Thailand has evolved with efforts to develop strategies for relevant responses. Documenting the perspectives, concerns and realities of migrants from Myanmar will

provide background for government, international and non-governmental agencies to consider in planning and implementing interventions to address their reproductive health needs.

3.3. Goal and Objectives of the Study

This study will document the reproductive health perceptions, concerns and realities of female migrants from Myanmar in Thailand in the broader context of their lives. The inclusion of male migrants as well as employers, government officials and service providers will also be an important aspect of this study. Clearly the reproductive health options and decision making process of girls and women are greatly influenced by her partners and larger social networks (Adams & Castle, 1994). Therefore, it is necessary that these also be understood and analyzed in this study together with female participants.

This information will be used to provide governments, international and non-governmental agencies in developing policies, programs and research that respond to the reproductive health needs and realities of female migrants from Myanmar. The data collected will be analyzed and published in both Thai and English language. The report will be widely circulated and formally presented at a workshop for Thailand's Ministry of Public Health (MoPH), other government departments and non-governmental organizations in the provinces where the research was conducted and national head offices in Bangkok. With this information it is hoped that an awareness of reproductive health realities among migrants from Myanmar will be raised and possible interventions

discussed and considered. At a minimum the research results aim to highlight the need for considering migrant populations in current reproductive health policies, programs and research.

The objectives of this research are:

1. To provide a profile of the reproductive health beliefs, concerns and realities of female migrants from Myanmar in Thailand, highlighting its relationship to the migration and violence they have experienced.

    a. identification of current belief systems that women use to interpret their reproductive health and care.
    b. identification of those features which women perceive to directly or indirectly cause women's health problems.
    c. identify constraints to improving their reproductive health.

2. To identify social networks of female migrants and the perspectives of male migrants, health care providers, government officials, employers and other community members on reproductive health issues concerning female migrants from Myanmar.
3. Describe female migrant's from Myanmar's health care and support seeking behaviors in Thailand (where, when, and from whom do the women seek care and support).

4. To identify appropriate communication, strategies and methodologies for further research of reproductive health issues which incorporate female migrants from Myanmar's perspectives, concerns and realities in the context of the migration and violence they have encountered.

In order to achieve the above goal and objectives, this study will be conducted in two phases. The objectives of each phase will be described below.

Phase One:

1. Describe the reproductive health beliefs, concerns and realities among those from Myanmar in the larger context of their lives as illegal migrants in Thailand.

2. Describe how their perspectives, concerns and realities impact their reproductive health and care-seeking decisions.

3. Identify obstacles and barriers faced by migrants from Myanmar in Thailand in dealing with their reproductive health concerns and needs.

Phase Two:

1. Describe the effects of migration on personal networks of female migrants from Myanmar in Thailand.

a. residential networks (whom do you live with)

b. work networks (whom do you work with)

c. social support networks (emotional, informational, and instrumental) related to reproductive health and violence

d. communication networks (who do you discuss reproductive health issues)

5. Assess the influence of personal networks maintained in Thailand on reproductive health care and support seeking behaviors.

6. Identify extent of violence and its impact on the lives of migrants from Myanmar and the impact on reproductive health and care-seeking decisions.

7. Describe reproductive health realities of female migrants from Myanmar in Thailand and their access to and use of services and commodities.

3.4. Research Design

Female migrants from Myanmar in Thailand will be the target population in this study. Migrants from Myanmar make up the largest illegal population in Thailand and females are most vulnerable to reproductive health morbidity and mortality. However, male migrants will also be involved in this study in recognition of their own reproductive health concerns and participation in the decision-making and shared

responsibilities with their partners. The following are the specific criteria used to define study participants:

The migrant population defined for this study included the following:

1). both female and male migrants from a given work site community;

2). all those between the ages of 15-50 years of age (in order to highlight current reproductive health perspectives, concerns and needs) and

3). All those self-reporting themselves as from Myanmar and not possessing a Thai ID card.

The study will not distinguish between those who have migrated voluntarily or involuntarily nor among those who have entered Thailand to reside permanently or temporarily.

3.4.1. Study Sites

Given the diversity of ethnicity and migrant workers' experiences in Thailand three distinctly different study sites were identified. The selection criteria for these sites are based on the ethnicity of the migrant population, type of industry and geographical location. The study will focus on three different industries, each located in different regions of Thailand:

- Fish and shrimp canning factories in Mahachai, a port town about two hours from Bangkok.
- Plantations in Chumporn or Pang-nga in the south[14]
- Construction sites in Bangkok or Chiangmai[15]

Sites in northern, central and southern Thailand were selected which included a wide range of ethnic groups from Myanmar. The three largest sectors of migrant worker employment registered with the Thai government were construction, agriculture and fishing related (see Table 1 and 2 above. Archavanitkul, et al., 1997) and therefore also selected for this study. However, the sites mentioned above may change, according to the accessibility to the migrant worker communities, which will have to be negotiated with employers and local authorities.

3.4.2. Data Collection Tools

This research will involve two phases at each site. Given the limited information available, the first phase aims to provide a deeper understanding and insight into their situation, cultural interpretations and issues impacting their reproductive health. This information will be incorporated into the second phase of the study to be carried out among a larger number of migrants

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[14] In the final proposal and actual study this site was changed to be plantations and mills in Ranong Province.
[15] Chiangmai was selected as the final site for study given its diversity from other sites in terms of location and migrant population.

Phase one will emphasize qualitative research methods allowing for narrative background on the definitions, language and perceptions of reproductive health by various migrant populations from Myanmar in Thailand. The qualitative based data collection tools will provide a more holistic and deeper understanding of the political, economic and social-cultural context which impact on individual experiences, interpretations and responses (Yoddumnern-Attig, Attig, Boonchalaksi, Richter, & Soonthorndhada, 1993). Three qualitative tools will be used to provide triangulation of the data collected. These techniques will include observation, in-depth interviews (IDIs) and focus group discussions (FGDs).

In phase two a questionnaire will be undertaken among a larger number of migrants. The data collected during phase one will be used to revise the questionnaire and ensure it reflects the issues raised and cultural background of the migrant populations involved. The questionnaire will seek more quantitative based data that will include a larger number of participants and provide a basis for drawing some generalizations and conclusions. The tools to be used in phase one and two will be described in more detail below.

Observation

The observation approached will follow the guidelines outlined in *Exploring the Context of Women's Health* (Gittelsohn, Pelto, Bentley, Bhattacharyya, & Russ, 1995 - See Appendix A). This requires a walking tour of the study area, brief notes describing the site and drawing a map of the community layout. The maps and notes will be compiled to describe each of the sites in which interviews for this study took place.

These will then be translated into English when necessary. Observations will be undertaken throughout the entire research period, as new sites are encountered and old sites relocated.

In-depth Interview (IDI)

The in-depth interview method was selected over others, such as informal, unstructured, and structured interviews, because of limited time in the field, and the need for flexibility. Informal and unstructured interviewing, where the control over the interviewing process lies in hands of the participant, is more appropriate when the researcher is in the field for a longer period of time and is able to interview the same individual on many separate occasions (Bernard, 1995). Semi-structured interviews, on the other hand, follow an interview guide, allows for similar degree of flexibly as unstructured interviews, but place more of the control in the hands of the researcher. The semi-structure will ensure consistency between study sites while at the same time remain flexible to the different cultures and languages of the various ethnic populations and environments.

Semi-structured IDIs will be conducted with migrant workers from Myanmar, with participants being comprised of two-thirds female and one-third male. In addition, health care providers, government officials, employers, community members and

organizations living and working in each area (referred to hereafter as key informants) will also be interviewed. At least 20 female and ten male migrants from Myanmar will be interviewed in-depth at each of the three geographical areas selected. In addition, at least five key-informants will also be interviewed in each study site.

IDI guidelines have been prepared for migrants (see Appendix B), key informants (see Appendix C) and key informants who are also service providers (see Appendix D). The interviewer guide consists of a written list of questions and topics specifying an order for how the inquiry should occur. The order is particularly important for this research, because of a number of seemingly distinct issues (reproduction health, violence, care and support seeking) and their sensitive nature. Inquiry on violence will take place only after questions about health concerns for the community and the individual, and social network and support have been posed.

The IDI guidelines for migrants from Myanmar will be translated into the language of the participants. These translations will then be back-translated and pre-tested for accuracy in content and cultural interpretations. The DID guidelines will be translated into Shan and Burmese for this study (see Appendices E and F respectively).

The in-depth interviews will be tape-recorded with the consent of the participants and assurance of confidentiality. The tapes will be transcribed in the language of the interview and translated into English. In addition, interviewers will add their own comments separately at the conclusion of the interview to provide a insight into the non-verbal and environmental impressions. The in-depth interviews of migrants

and key informants as well as the comments by researchers are an effective means of comparing and validating data collected (Yoddumnern-Attig, et al., 1993).

Focus Group Discussion (FGD)

The FGD method was selected because it involves group interaction which will enrich responses, in particular with regards to community norms and values; allows flexibility, which is critical since there is little basic information about this population; provides culturally appropriate language, and costs relatively less (Krueger, 1994). FGDs with migrant workers will be used to (1) understand belief systems and language used in labelling and interpreting health problems; (2) assess the community's perceptions of reproductive well-being given other economic and safety issues; and (3) identify health care concerns, access issues and support seeking behaviors. To be concise, a main objective of conducting FGDs is to provide insights on how migrant workers perceive their reproductive health, concerns and realities together with community members and discuss the factors affecting their health care decisions.

Participants of focus groups will be male and female migrant workers. In determining the size of the focus group, Krueger (1994) stated that the group needs to be small enough to allow for every individual to have an opportunity to express their points of view, but large enough to achieve diversity of views. In this situation, six to eight people will be recruited for each FGD. Selection of the location to conduct focus groups will be based on safety, neutrality, and confidentiality. It is critical that migrant workers feel safe and comfortable to discuss issues that may place them in great danger,

or at possible threat from police or employers. At least two focus groups will be conducted for each variable relevant to the topic (Krueger, 1994). For this research, the key focus group variables are identified as gender and ethnicity. Gender distinction is important, owing to the sensitive and sexual nature of the topics and to differences in discussing, experiencing, and interpreting issues of reproductive health. Ethnicity will be the other factor in defining the focus group participants in order to ensure that the participants speak the same language and share similar cultural backgrounds. A minimum of four focus groups will be conducted at each of the three locations two male and two female for each ethnic population.

The FGDs will use the same interview guidelines as the IDI (see Appendices B, E and F). The FGD data will be collected using a tape-based analysis strategy, which will involve listening to the tape and preparing a brief transcript (Krueger, 1994). In addition to comments from participants, this transcript will include moderator's and observer's comments, which will attend to nonverbal communication, such as body language, and level of energy. This strategy is selected over a more rigorous and time intensive complete translation of tape and notes. This strategy is also more appropriate than memory-based or note-based strategies. Taping allows for the researchers to grasp the exact use of language and style of speech. The participants will be reassured that although the focus groups are taped, the individuals will remain anonymous and results confidential.

Questionnaire

The questionnaire will be undertaken to expand the number of study participants and provide a larger population to compare and contrast the qualitative based data collected in phase one. The questionnaire will explore social networks (Valente, 1996) of migrants, the impact of migration and the influence it has on reproductive health decision, care-seeking behavior and exposure to violence.

The questionnaire will include both open-ended and close-ended questions, and will be divided into three sections (see Appendix G). The first section of the questionnaire will focus on the demographic characteristics, and migration history of the participants. In addition to age, gender, ethnicity, place of origin, marital status, income, and education, migrant workers will be asked about the length of time in Thailand, mobility and knowledge of Thai language. The second section of the questionnaire will collect personal network data such as with whom they live, work, seek emotional support and discuss reproductive health problems and encounters of violence. Each respondent will be asked to name individuals in their networks and provide demographic information, the type of relationship and the types of activities, support and conversations topics shared. The final section will inquire about their reproductive health, decision-making, care seeking behaviors and experiences with violence.

The questionnaire will be translated from English into the local languages of migrant populations.[16] The first translations will then be back translated and field tested for context and cultural interpretations. Questions and wording will be adapted to accommodate the language and grammatical differences to obtain appropriate and consistency in meaning and responses.

3.4.3. Sampling Size and Strategy

Nomination and snowball sampling methods will be used for both phase one and two data collection techniques. Nominations will be conducted through non-governmental organizations (NGOs) and local community leaders. Once the site and initial migrant workers have been selected, they will be asked for names of others to be interviewed. As the goal of this study is not to test a hypothesis or make generalizations to all migrant populations, the representativeness of the sample is not critical issues. The challenge of access to and safety of the participants is assumed to be of utmost concern. Therefore, relying on community-based introductions will be invaluable in assessing and minimizing any risks.

The sample size for phase one will be to conduct at least 20 IDI with female migrants and ten with men at each field site. In addition, a minimum of four focus groups will be conducted of two female and two male FGD at each field site. Observations will be carried out at each work and living site where migrants were

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[16] The questionnaire was translated into Shan and Burmese language (see Appendices H and I respectively). 3.

interviewed. IDI will also be conducted with key informants as they are identified in each field site.

The sample size for phase two of the study was calculated to require a minimum of 154 interviews at each of the three study sites. This was determined by setting the significance level at .05 and the power at .80 (the minmum). The proportion of the population with either reproductive care and health seeking behaviors or exposure to violence is estimated at .5 (a conservative estimate) and the maximum tolerable amount of error at .05. Finally an estimated refusal rate of 20 percent was also included.

3.4.4. Research Teams

The research team will consist of a project coordinator and three principle investigators, each employing two or three research assistants. The project coordinator will be based at the Institute of Population and Social Research in Mahidol University. Each principle investigator will manage one study site, and provide guidance and support to the research assistants. All of the research assistants will be recruited from the migrant communities from Myanmar in Thailand and will be fluent in the languages of the study population. As full time staff for six months, the research assistants will be involved throughout the entire research process – developing interview guidelines and the questionnaire, gathering data in both phase one and two, transcribing, coding and analysis. Before each phase of data collection begins research assistants and principle investigators will undergo training on key aspects of the research (such as reproductive health concepts, research methodologies, ethics of conducting social science research,

ensuring confidentiality and consensus on the interview guidelines and questionnaire and their translations).

3.4.5. Coordination and Training

The team coordinator and principle investigators will meet frequently to coordinate the research, its design and data collection tools as various issues and situations arise. This will be necessary to ensure a shared vision of the proposal and consistency in conducting the research between each field site.

Trainings will be carried out prior to each phase and in the final analysis of the data collected. The entire research team will participate in all trainings. Experts will be invited to provide technical input on reproductive health issues, migrant populations and data collection tools. The training will train the research team on key issues and data collection tools and work towards a consensus and consistency in the research process between teams in the different field sites. In addition, the training sessions will provide a forum to discuss and give input to the data collection tools and analysis.

3.4.6. Data Analysis

Various data analysis methods will be used to interpret the data collected in phase one and two of this study. The qualitative based data collected during phase one will be analyzed using the Ethnograph 4.0 computer program. Based on the transcripts and observer notes, the analysis will include identifying themes, developing coding

categories (see Appendix J). The data will then be coded and sorted according to these categories (Krueger, 1995). The socio-demographic variables collected in phase one (see Appendix K) of the study will be placed on a Microsoft Excel computer program spreadsheet. The data collected by the questionnaire during phase two will be analyzed using the SPSS 7.0 computer program. The data from each site will be entered separately to facilitate comparisons and contrast of the findings.

3.4.7. Limitations of Research Design

The most obvious limitation in this study is the limited number of study sites and migrant populations that will be included. Migrant populations from Myanmar come from a wide range of ethnic minority groups who are uniquely different in language, culture and background environments. In addition, migrants from Myanmar are working throughout Thailand in many diverse labor sectors. The selection of sites, labor sectors and ethnic populations in this study is extremely limited and will not allow for conclusive data in describing female migrants from Myanmar as one entire group.

There are also limitations in selecting the data collection tools. The research tools to be used in phase one will provide for more in-depth understanding of a very small population. This will allow for time and care in raising sensitive issues likely to offer more a detailed and qualitative response. However, the small number of participants will make it impossible to draw specific conclusions regarding the larger migrant population. In addition, it will be difficult to translate accurately the language

and perceptions of migrants to these open-ended questions and analysis of long narrative text is difficult and time consuming. FGD will provide insight into the community interactions and social responses to the reproductive health issues. This will provide some understanding of the dynamics within the community, however given that each focus group is small and unique again generalization is not possible. Finally, the data collected through observation, IDI and FGD are influenced by the researchers themselves who will be actively involved in the framing of the open-ended questions, probing and in analyzing the responses.

The questionnaire to be used in phase two of this study will be based on the findings from phase one and will aim to incorporate the language, culture and perceptions identified. The questionnaire will allow for the participation of a large numbers and with limited influence from the researchers. However, the questionnaire does not allow for a careful proving and cross-checking of indirect or misleading responses which are common when sensitive issues are raised. The short responses will not give much insight into the why or how of events or beliefs reported nor will it provide a means for distinguishing the truths from the easy and perhaps inaccurate responses.

The combination of data collected from phase one and two will provide a means for triangulation of data that will compliment the strengths and weaknesses of each specific research tool. However, given the diversity among migrant populations from Myanmar and the dynamic environments they face in Thailand, generalizations or specific explanations will be inadequate and incomplete. The results of this study will

provide insight into some of the reproductive health concerns, realities and needs found among migrants from Myanmar in Thailand and open a discussion of the issues and areas for further research needed to address them.

3.5 Ethical Considerations

In addition to standard ethical considerations of conducting research with human subjects, such as obtaining informed consent, there are several other related issues that have been considered in undertaking this research on reproductive health among migrants from Myanmar. This research recognizes the gender-based violence raises the level of confidentiality of information, physical safety of researchers and informants, need for specialized training of interviewers, and responsibility of the researcher to provide informational materials, referral services, and crisis intervention. The last point brings to attention the need to collaborate with local organizations and service providers. Particpants will be provided with available publications or contacts on reproductive health issues and when necessary make referrals to additional support networks identified in the area.

Voluntary participation

At the time of recruitment, potential participants will be fully informed about the nature of the study and given an opportunity to ask questions or express concerns. Assurance of confidentiality will be emphasized. The potential participants will also be

told that their decision to be interviewed is completely voluntary. Participants will also be informed of their right to refuse any or all questions asked.

Confidentiality

Most migrant workers are illegal (particularly among those who have not obtained work permits) and face threat of arrest and deportation; thus, confidentiality is of utmost importance. Therefore, confidentiality will be ensured by maintaining data records with identification numbers rather than names. Interviews and other data will be stored in locked files both in the field site and Bangkok upon completion. Only research team members will have access to the data.

Ensuring safety of participants and interviewers and researchers

The interviews and focus groups will take place in safe and neutral place. In collaboration with local NGOs and community leaders, great effort will be taken to identify locations where participants are approached in safety and confidentiality. In situations where the environment changes and assessed to no longer ensure the safety and confidentiality of the participants, the interviews will be stopped. Finally, letters of approval for this research will be obtained from several Provincial government offices. These letters will be carried by all those involved in this study for their protection and those of the participants.

Mechanisms for coping with potential trauma

A list of resources and materials will be developed for participants who request more information on relevant topics (family planning, reproductive tract infections, and sexual violence) and on available services (including clinics, health centers, women's NGOs. Local groups will be contacted and up-dated on the progress of the research and a referral system will be agreed upon and revised as necessary prior to and throughout the study.

3.6 Timeline

The entire research project will take eight months to complete.

Month 1	recruitment of interviewers, selection of areas, and training interviewers.
Month 2-5	data collection.
Month 6	data analysis.
Month 7	write up report.
Month 8	policy workshop to discuss and disseminate findings and recommendations.

3.7 Budget

A number of steps were involved in developing the budget as described in Kaewsonthi and Harding (1992). The first step required a further breakdown of activities outlined in the timeframe above. Each activity was then noted for the

resources required for their implementation including personnel, materials, equipment, transportation, accommodation, communication and other allowances. The figures below are a combined estimate for the overall project and each field site. An institutional fee for the Institute of Population and Social Research (IPSR), Mahidol University for overseeing and managing the project was then added to the amount below. This was negotiated between IPSR and each donor.

The proposed budget below is calculated in US Dollars.

(1) Personnel (% time devoted)

Project Coordinator (50% time); $500 x 8 months	4,000
Principal Investigators (100% time); $750 x 8 months x 3 persons	18,000
Research Assistants (100% time); $300 x 4 months x 6 persons	7,200
Secretary (100% time); $300 x 8 months	2,400
sub total	31,600

(2) Data Collection

2.1 Training research assistance and pretesting	1,500
2.2 Transportation	3,000
2.3 Out of Base Allowance during fieldwork for Research Assistants;	
meal and accommodation $20 @ day x 90 days x 6 persons	10,800
2.4 Out of Base Allowance during fieldwork for Researchers;	
meal and accommodation $20 @ day x 60 days x 3 persons	3,600
2.5 Compensation to migrant workers	500
2.6 Data processing and analysis	1,500
sub total	20,900

(3) Communication and Administration

3.1 Phone, fax, mail	2,000
3.2 Tape recorders; $100 x 6	600
3.3 Photocopy and stationary	2,000
3.4 Policy workshop	3,000
3.5 Publishing Report (Thai and English; 500 copies each)	4,000
sub total	12,000
GRAND TOTAL	65,000

The proposed budget above was shared with a number of different organizations and donors to compare these costs with the work proposed. The donors approached were foundations and government funded institutions with a known interest in reproductive health and migrant populations. Several donors showed an interest in the project proposed and explained their format for proposal and budget submissions. The proposal and budget was revised according to discussions with the donors and format for project proposal submissions. Two different donors funded the final project. World Bank funded phase one in two field sites and Ford Foundation supported the third site in phase one and the entire phase two of the project. World Bank was largely interested in HIV/AIDS among migrant populations and it was agreed that a report highlight this would be submitted to them from data collected in two field sites during phase one of the study. The Ford Foundation was interested in the overall objectives of the study and gives priorities to projects that have matched funds from other donors. The final report of the entire study, its translation into Thai and presentation was included in the funds provided by Ford Foundation.

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