

Executive Summary

The PHAMIT-2 (Prevention of HIV/AIDS among Migrant Workers in Thailand) Project has been implemented during 2009-14, and is an extension of PHAMIT-1, which spanned 2004-2008. The principle goal of PHAMIT is to reduce the number of new infections of HIV by providing comprehensive prevention services to foreign migrant workers (MW) from Myanmar, Lao PDR and Cambodia who have risk for HIV. Under this goal are three objectives: (1) To strengthen and expand integrated HIV prevention services for the target population; (2) To create an enabling environment for equal and sustainable HIV services for the target population; and (3) To strengthen the strategic communication system for use in improving policy and programs for the target population.

The 2014 survey to assess the impacts of PHAMIT involved the collection of quantitative and qualitative data, and assessed the benefit of participating in the Project by the MW community. The evaluation also examined the extent of cooperation provided by implementing allies in the service network and response of the MW population. The evaluation assessed to what extent PHAMIT achieved its targets and objectives, including performance of the stakeholders such as staff of the partner agencies in the field implementation network. When collecting data from the MW population, this evaluation communicated in the national language of the MW to maximize understanding of the content and accuracy and completeness of the findings.

Part I. Results of the Quantitative Component of the Evaluation

Characteristics of the MW

Most of the MW in this study are in the younger range of the working age years. Over two-thirds were under 35 years of age, with an average between 28 and 29 years. Most MW were between the ages of 20 and 29 years, which reflects the demand for MW in the occupations which require stamina and hard labor. The male MW have slightly lower average age than the females, and this is similar to the findings of the previous survey round in 2010. Almost all the sample had attended school in their home country, while a few had gone to school in Thailand before joining the labor force.

Most of the Burmese MW work in industrial labor and the fisheries (deep sea and coastal fishing, and seafood processing factories). Most of the Cambodian MW work as fishing boat crew and in seafood processing factors. The Lao MW mostly work in industrial factories and agricultural wage labor. These findings are similar for both the 2010 and 2014 survey rounds. Over half the MW have work permits, and MW income increased significantly between survey rounds (perhaps reflecting the increase in the minimum wage law) though still lower than the current minimum wage by law.

Knowledge, Understanding and Attitudes toward HIV/AIDS

Knowledge of HIV/AIDS among the MW is good. Almost all MW understand that HIV is preventable, and that condoms prevent sexual transmission of HIV (92% and 87% in 2014 and 2010 respectively). It is praiseworthy that HIV/AIDS knowledge has reach such a high level, but there is a need for improvement in understanding among some groups of MW of the routes of transmission.

The MW have a low self-risk assessment of HIV (under 10% feel at risk) however, in 2014, as high as 41% of the female Cambodian MW felt they had some risk of infection. The extent to which the MW feel that HIV is “near them” is probably a good predictor of motivation to practice prevention. That said, most MW still feel that condoms are a man’s responsibility and this viewpoint has not changed since 2010. What is more, the proportion who feel that “good women” do not carry condoms increased over rounds. The Lao MW were more likely to agree that the woman in a relationship could motivate her partner to wear condoms, even though they still believe the man should provide the condoms. By contrast, distinctly fewer Burmese and Cambodian MW felt the woman could influence her partner to wear condoms. Thus, motivational campaigns for condom use need to expand the conceptual thinking and norms of the MW about the role of women and men in condom use.

Also, the Lao MW were more tolerant of the concept of same-sex relationships than the Burmese or Cambodian MW. This points to the need for safe sex messages to reach the vulnerable populations of MW who experience social stigma, especially the Burmese men.

The Lao MW felt that access to condoms was convenient while a smaller proportion of the Burmese MW felt they had convenient access.

Knowledge, Understanding and Prevalence of Sexually Transmitted Infections (STI)

One of the Project indicators of success was the knowledge that having an STI increases risk of acquiring HIV, and 90% of the MW in both survey rounds knew this fact. While less than one percent of MW reported genital discharge or foul genital smell in 2010, fully 8% reported one or both of these symptoms in 2014. Most of the MW said they would prefer to seek care at a government hospital if they had STI symptoms, followed by health center, NGO or private clinic. The proportion who said they would self-treat declined over rounds, and the Cambodian MW seem to be in greater need for STI services than the other groups.

Source of Information on HIV/AIDS

In 2014, TV was the preferred source for information in all groups of MW. The MW also observed that there is print media on HIV/AIDS which they can read at their leisure, which is an advantage over the TV and radio messages. However, the limited literacy of some of the MW, especially for Thai language media, makes printed educational media the less-preferred channel for AIDS knowledge, and this was true for both survey rounds.

About half the MW said they were knowledgeable about AIDS before travelling to Thailand. After arriving in Thailand, distinctly more of the MW said they received AIDS information themselves or from family members who were exposed to awareness campaigns and orientations on STI/HIV/AIDS. The most common areas of new learning in Thailand include contracting HIV and prevention, condom use, and STI (both rounds).

Consistent use of condom is one of the effective practices for HIV prevention, which can also be used as a contraceptive method for family planning purpose. Access to information about condom use enhanced MWs to know better about proper use of condom which, as a result, would encourage them to use condom more consistently. From this survey, about two-thirds of the MW reported receiving ample information about condoms, and this level was the same for both survey rounds. Common sources of condom information were educational group discussions, training, lectures, and printed brochures/pamphlets, or posters.

Knowledge of HIV voluntary counseling and testing (VCT) increase between 2010 and 2014, especially among the Lao and Cambodian MW. Common sources of knowledge include educational group discussion and training or lectures. NGO clinics were a key source of information about VCT as well as Migrant Health Volunteers (MHV), Migrant Health Workers (MHW), and NGO field staff.

Sex Behavior and Condom Use

Age at first sex for the MW was 21 years in both the 2010 and 2014 surveys. Among those age 15-24 years, the proportion having their first sex under age 15 increased over time. Thus, awareness campaigns on safe sex, HIV/AIDS/STI need to include MW under age 15 years.

Regular Sex Partner

More of the MW in the 2014 survey were sexually active with a spouse/regular partner than in the 2010 survey. Condom use with a regular partner increased from

11% to 18.6% across rounds for all nationalities. The reason for using condoms was mostly for contraception, followed by STI/HIV prevention. There was also an increase in condom use for all sex episodes and last episode of sex when comparing 2010 and 2014 survey rounds.

Casual Sex Partner

The proportion of MW who admitted to having sex with a casual partner in prior 12 months - though increased in this round as compared to the baseline one - was very small. Of this, the proportion was obviously higher for male MWs than female MWs. Those who did have sex with a casual partner reported increase condom use across rounds.

Commercial sex worker

On this issue, only male MW are counted. The two rounds of surveys of MW found that the Cambodian MW were more likely to have had sex with a sex worker, though the proportion declined over rounds from 34.3% to 13.3%. Among Lao MW, the proportion having had sex with a sex worker also declined, from 10.5% to 6.6%. By contrast, the proportion of Burmese MW who had sex with a sex worker increased slightly from 3% to 4%. This finding could be partially due to the fact that more of the Burmese MW are living with their spouse while in Thailand, especially when compared with the male Cambodian MW, most of whom are working as fishing boat crew and are most likely to have had sex with a sex worker.

Condom use with sex workers and casual partners in the past 12 months increased over rounds as did condom use at last sex with a sex worker (from 75.1% to 79.4%). Condom use at last sex with a sex worker increased from 92.8% to 93.7% between rounds.

Factors Inhibiting Condom Use

A principle reason for not using condoms with one's sex partner is use of addictive drugs (mostly among the male MW). Male MW reported using addictive drugs before having sex with a sex worker more than with other types of partners. However, this practice declined from 83.3% to 63.5% between 2010 and 2014. Only a small proportion of female MW felt that condom use reduced pleasure during sex. By contrast, most of the male MW felt that condom use with a casual partner or sex worker reduced pleasure, and this was evident in both survey rounds.

Confidence in ability to motivate one's regular partner to use condoms improved significantly over rounds (from 38.5% in 2010 to 63.6% in 2014). Confidence of male Burmese MW in being able to persuade their casual sex partner to use condoms

increased from about 80.5% in 2010 to about 90.0% in 2014, and to persuade commercial sex partner to use condoms increased from 80% to 89.3%, respectively.

Respondents were asked how to manage a situation in which their partner refused to use condoms. In 2010, over half of both male and female MW would consent to sex without a condom with their regular partner. By 2014 however, the proportion who would consent declined in all groups, and more would try to negotiate condom use with their partner. The proportion of male MW who would refuse to have sex if their casual partner did not want to use condoms doubled from 19.2% to 38.2% over rounds, while of those who would consent to have sex decreased from 30.8% to 19.1%. The proportion of those who reported that they would negotiate and explain reasons to the sex partner also decreased from 50% to 39.7%. The pattern is similar for sex with a commercial sex worker, as the proportion of male MW who would consent to have sex without a condom decreased from 21.6% to 6.3% over survey rounds. The proportion of those who would refuse to have sex also decreased from 66% to 54.7%. Conversely, the proportion who would try to negotiate condom use tripled from 12.3% to 35.9%.

Over all, for all types of sex partners, attitudes and intention to negotiate for condom use and safe sex improved between 2010 and 2014.

Voluntary HIV Counseling and Testing (VCT)

The proportion of MW of all three nationalities who knew a place where they could have VCT increased from 50.4% to 70.5% over rounds. It is noteworthy that more women than men knew of a VCT service site in 2014, while the reverse was true in 2010. Among those who knew of a VCT site, two-thirds cited “government hospital” while one-third cited ‘health center’ or ‘private clinic’. As of 2014, one-third of the MW had ever received VCT, representing a five-fold increase over the level in 2010. The main reasons for seeking VCT include requirement for employment, part of ANC care, and desire to know about their status. For site of last VCT service, three-fourths had gone to a government hospital. Only one-fourth of MW who had ever had VCT before had been tested in the past year. In 2014, of those who had an HIV test in the past year, only about half received pre- and/or post-test counseling, which represents a decline from the level in 2010. Of those in the 2014 survey who had been tested, 85.0% knew the test results, but this is also a slight decline from the level in 2010. In most cases, the HIV test results were kept confidential, except when the MW wanted a close relative or friend to be with them when hearing the results. The proportion of MW in 2014 who reported receiving their test results alone was a bit lower than the proportion in 2010. For those who received the results with someone else, the majority

received the results with friends or colleagues, and some did with relatives and spouse.

Family Planning

The level of knowledge of modern contraception for both married and single MW is similar for 2010 and 2014 rounds of the survey. The most common method known is the pill, followed by the injectable, condoms, and female sterilization. There was an increase in knowledge of the condom as a contraceptive over rounds. All three nationalities had reported ever-use of modern contraception, with the pill being most commonly cited (though the proportion declined slightly over rounds). Among married or cohabiting MW, the contraceptive method currently used is most likely to be the pill, followed by the injectable, and this pattern and level is similar for both survey rounds.

The proportion of married MW women age 15 – 49 years with at least one child increased from 50% in 2010 to 77% in 2014, and the increase was sharpest for the Burmese women (50% to 76%). The decision to have a child is usually a joint decision between the partners and this has not changed over rounds. In 2010, the average number of children desired was 2.85 (mode = 3) while in 2014 the number declined to 2.68 (mode = 2).

Access to Health Services

Fully 84.9% of MW of all three nationalities in 2014 reported having had an episode of illness or injury in the prior 12 months which required clinical care. While incidence of illness/injury is slightly lower than the corresponding proportion in 2010 (91%) the level is still high. The pattern of health care seeking has not changed between survey rounds. Most MW seek care at a government hospital; next most common is to seek care at the local health center or private clinic. It is noteworthy that some MW seek out the services of a traditional healer (28% in 2014 and 15.2% in 2010). In 2010, the main reason given for not seeking health care at a government outlet was lack of an ID card, symptoms were not severe, or the long wait time. In 2014, the principle reason for not seeking care at a government health facility was also lack of an ID, but the second most cited reason was the remote location of the facility, or the belief that they did not have right to access subsidized treatment at the government outlet since they had no health insurance care. Language barrier was not an important reason for not seeking care at the government outlets. The reason cited for not seeking care at a private health facility in 2014 Survey was the cost of care, while second and third reasons in 2014 were remote location of the private outlet and symptoms not severe. In both 2010 and 2014 the reason given for not seeking care a local health center was lack of knowledge about location and lack of experience with this type of outlet.

In the 2014 survey, half of the MW who had an illness in the past year sought care from a government hospital for their latest episode, and this was higher than for 2010. The proportion who self-treated or sought care at a clinic or NGO declined over rounds.

Two-thirds of MW in 2014 were “very satisfied” with the treatment they received for their latest episode of illness/injury, while one-third were “rather satisfied.” Two-thirds also felt the health service was “very convenient” with the minority describing it as “rather convenient” or “inconvenient.” The most common persons cited who helped the MW access health care were the employer and spouse/partner. Secondary sources of help in accessing services were friends (co-workers and/or neighbors) MHW or MHV. The assistance included accompanying the MW to the service site, helping translate, and helping to explain the service system of care.

Provisions of specific health services for MWs (e.g. patient referral, counselling, VCT, STIs testing and treatment, HIV and STIs prevention, and free condom distribution) within the past 12 months varied by responsible SRs of each area. Access to these services by MWs, thus, depended on activity plans as determined by the project indicators that the SR targeted to achieve.

Approximately half of the MW reported that they had health insurance (e.g., from the MOPH program for MW) while only 6% reported having a Thai social security card.

Part II. Result of the Qualitative Component of the evaluation

Structure, mechanisms and system of implementation

Management: Differences between PHAMIT-1 and 2

PHAMIT-1 operated by the Raks Thai Foundation (RTF) as the principle recipient (PR) under an agreement with the Bureau of Health Administration (BHA) of the MOPH as a Global Fund sub-recipient (SR). This gave the BHA overall management responsibility for PHAMIT-1, and for assigning roles of the implementing partners. Thus, the implementation relationship between the PR and SR was rather close. However, with PHAMIT-2, there was a change of personnel and management system of the BHA, and the contractual agreement was not executed in a timely way. To adapt to the management vacuum, PHAMIT-2 arranged for the PR to enter into agreements directly with 10 provincial health offices (PHO) with corresponding allocation of some implementation budget to prompt the PHO to take responsibility for training health care providers and staff how to deliver migrant-friendly services.

Mechanisms of Project advocacy

Joint Strategic Management Committee (JSMC)

The JSMC was first created during PHAMIT-1 and comprised senior managers of each of the implementing partner agencies. The JSMC's meeting was scheduled regularly in every 3 month period. In PHAMIT-2 the membership of the JSMC was expanded to include more field implementation managers. In PHAMIT-1, the JSMC had a broad oversight function and could monitor the overall Project strategy and policy. In PHAMIT-2 the JSMC had more input from the field implementation level but to some extents lacked a complete picture of the overall Project and strategy.

Provincial Coordination Mechanism (PCM)

Under the SSF Round of the National AIDS Program, the PCMs were created as the principle coordination mechanism at the provincial level to align strategic implementation for the target populations. Support budget is provided to the PCM through the PHO. The level of involvement of the PCM in Project interventions with MW varies depending on the strength and interest of the provincial staff. In the provinces with stronger management, there is good coordination between the PHO, the NGO partners, and public and private service providers to increase the access to services for MW, especially in the area of VCT and diagnosis and treatment of STI.

Migrant Health Workers (MHW) and Migrant Health Volunteers (MHV)

A core strategy of both PHAMIT-1 and PHAMIT-2 Projects is the cadre of MHW and MHV to improve MW access to information and services for prevention of HIV and other basic health care. The MHW are migrants who have been recruited, hired and trained by the Project implementing partners. They have different position titles. For example, the MHW hired by the Raks Thai Foundation are called Field Office Migrant (FOM), whereas the World Vision Foundation (Thailand) MHW are called Front Line Social Network (FSN). The MHW are key players in the front-line services of the Project. The PHAMIT-1 and PHAMIT-2 Projects provided budget for MHW to be assigned to hospitals in the target provinces, and this gave these facilities important experience in the use of this auxiliary health worker.

The MHV are MW who work in the community or worksite on a voluntary basis and do not receive any financial compensation for their work (except for reimbursement of travel costs to Project activity sites). The role of the MHV is to provide a link for MW with training opportunities and other learning activities. The MHV restock condom dispensers, and distribute condoms and educational media during outreach visits.

Outreach

Target populations of the Project

The Project has faced challenges reaching the MW who work in the agriculture and construction sectors, and this is true for all the Project provinces. Another group that is not well-covered are the male and female youth. Some of the MW populations marry at a young age (e.g., 13 to 14 years) but they are missed by the Project since the target population is defined as those age 15-45.

In PHAMIT-1 there was higher priority on reaching MW working in the commercial sex industry than in PHAMIT-2 since sex workers were not listed as part of the target MW population in the CHAMPION umbrella project. In a few Project locations the SR and/or sub-SR arranged for the PHO or provincial hospital to deploy mobile units to entertainment establishments with MW service workers, but coverage of this group did not count toward the Project indicator targets.

Outreach activities for behavior change

The Project's standard content for outreach education are contained in the HIV and STI knowledge packages. In PHAMIT-1, other content areas included reproductive health, MCH and family planning but these were de-emphasized in PHAMIT-2. The method of implementation was similar across provinces and involved the creation of cadres of MHW and MHV as the key strategy for reaching the target population. In addition, drop-in centers (DiC) were established in areas with a large number of MW to improve Project public relations and increase interaction between the Project staff and MW community. The DiC also serve as learning centers for MW. The design of the DiC differs among locations depending on the local context.

Free condom distribution was a feature of the small group activity sessions conducted by Project field staff and MHW. Peer educators provided education for the MW at the DiC, and condom dispensers were placed in various locations in the community to improve access for MW. The Project met its condom distribution targets.

The Project staff felt there were enough educational media provided by the Project, however there were complaints that the Lao-language versions were inaccurate or had errors in grammar.

Capacity Building

Strengthening the field staff and MHW

The Project implements an annual training with standard curriculum for staff capacity building as set by the project activity plan. Participants include staff from the head and field offices of the SR, along with the MHW. This annual refresher training points to the need for continual reinforcement and refresher learning for the Project staff, especially in the area of effective communication for accessing the target population in the community setting.

The field staff and MHW also conduct capacity building for the MHV and peer leaders, however some areas do this informally without a standard training curriculum. The orientation includes review of the role of the peer educators, the basic set of information about HIV/AIDS, STI and VCT, MW rights, and health services at the different types of hospitals. Some implementing partners involved in TB projects also provide capacity building in this area.

Monitoring and technical assistance

As noted above, the PHAMIT-2 Project experienced delays in processing the agreement with the BHA, and this hindered field support for the public health outlets. Thus, the technical assistance for the PHO and related agencies was limited. Accordingly, the Project conducted monitoring of the local health outlets by phone contact and by interaction during various forums.

Health Services and Access

MW-friendly services

Service providers were not able to list specific things that BATS or the PHO promoted in order to make services more client-friendly for the MW population since staff from a wide range of sections were involved. Nevertheless, the many years of experience with PHAMIT has instilled a sensitivity among the local health providers to the needs of the MW population, and this has been institutionalized to a certain degree.

Client referral

MW clients who need referral to other service outlets in the network are accompanied by the field staff, MHW or MHV as required. The MHW and MHV coordinate with the health provider and serve as interpreter as needed. In most of the Project sites

there is a linked network among the SR and provincial outlets such as the Sub-district health promotion hospitals and other public health centers.

Mobile unit services for VCT and STI

In addition to the static clinic health services, the Project PR provided budget to support the PHO to deploy mobile VCT and STI clinics to MW communities. Initially, at least one mobile clinic visit was scheduled for each targeted MW community. Later, this was increased to two visits per quarter. There were limitations of time and personnel to operate the mobile service. In some provinces (SamutSakorn, Ranong), Burmese physicians joined the team.

Quality of services

Pre-test counseling for VCT was not always provided, and post-test counseling was conducted in small groups. The duration of time from taking the blood sample to hearing the results varied in different outlets. Most MW who were tested were followed up to ensure they received their results. Staff observed that VCT with same-day results is the most appropriate model for the MW community.

Access to health insurance for the MW

About the Migrant Health Insurance Policy that was adopted in August 2013, it was found that the conditions for purchasing a health insurance card by MW were not clear-cut, communication from the policy level to the province was also weak on this topic. Thus, implementation is uneven across provinces. Some provinces have established their own criteria for making the insurance available to MW (e.g., must be a legal MW, must have a 13-digit ID card or Thor Ror 38/1). To provide coverage for children of MW, some hospitals require the MW to purchase a health insurance cards for the whole family.

Participation of Stakeholders

Participation of stakeholders in the Project is passive in that the stakeholders are informed of the Project and facilitate access to the target population but are not actively involved in planning and implementation of interventions. This is due to the fact that the local administrative organizations and MW worksites do not have a policy to implement health care interventions for the MW. The human resources section of the MW worksites in many of the Project provinces have a favorable

attitude toward PHAMIT-2 and are happy to collaborate as needed by allowing Project staff access to the MW at the worksite. However, some Project staff observed that some Thai community leaders have a negative attitude toward the MW and see them as a source of problems, infectious disease and crime.

Recommendations

This evaluation has provided a clearer picture of the achievements of the Project partners in the network in the planning and strategic implementation of interventions for MW. The effort and dedication of the field staff is exemplary and morale is high despite the occasional challenges and set-backs. Thus, it can be expected that there will be continued improvements in condom use, prevention of STI and HIV, healthier behavior, and knowledge of rights for promoting health among the MW and Thai populations going forward.

The followings are some of the key recommendations from the evaluation result.

- Condom promotion campaigns need to be more sensitive to the respective roles of the man and woman in a partnership, and how this differs across the three cultures of the MW;
- Safe sex promotion campaigns need to access the at-risk MW who are victims of social prejudice, with interventions that are tailored to their lifestyle and context;
- There are some Burmese MW who do not feel they have convenient access to condoms when needed. Thus, there is a need to increase condom distribution outlets or increase knowledge and outreach on how to obtain condoms;
- Some MW prefer to self-treat at home for symptoms of STI or to let nature take its course. Thus, there is a need for more campaigns to motivate MW to access proper medical care for STI symptoms;
- Uptake for VCT in 2014 is slightly lower than for 2010. Thus, there is a need for continued motivation and campaigns to encourage MW with some risk for HIV to seek VCT;
- It is still not clear how the MHW can be institutionalized in the routine Thai health system. This is because of issues around hiring non-Thais, appropriate compensation rates, and the high turnover of the MW population. There are budget limitations for hiring MHW and training of MHW. Solutions in this area need to be found;
- The DiC in some locations have low visitation rates and may not be cost-effective. There needs to be a guaranteed and sustainable source of budget support for DiC so that they can be cost-effective in the MW communities that need them;

- Some VCT outlets do not adequately protect the confidentiality of MW clients and this could deter some MW from seeking VCT. The services need to be improved so they are more client-friendly;
- It has been observed that some Thai community leaders have negative attitudes toward MW and see them as a source of disease and crime. Centrally, there needs to be more collaboration at the ministerial level to promote policies which create a more enabling environment for health programs for MW at the field level.
- Provision of health literacy and knowledge on safe sex, AIDS and STIs is recommended to also target on those with age below 15 years.

Table of Contents

Executive Summary	page
	a
Table of Contents	i
List of Tables	iv
List of Figures	iv
Chapter 1 Introduction	1
1.1 Background and rationale	1
1.2 Components and objectives of the evaluation	2
Chapter 2 Background of the PHAMIT 2 Project	3
2.1 Background of the PHAMIT 2	3
2.2 Goal, Objectives and Target Groups	3
2.3 Area of implementation	4
2.4 Project strategy	4
2.5 Implementation activities	8
2.6 Overview of Project indicators	13
2.7 Duration of Project implementation	15
2.8 Review of the findings of the 2010 Baseline Survey	15
Chapter 3 Methodology of the Evaluation Survey	19
3.1 Quantitative data collection	19
3.2 Qualitative data collection	24
Chapter 4 General characteristics of the sample of migrants	27
4.1 Age-sex distribution	27
4.2 Ethnicity	28
4.3 Marital status	28
4.4 Education attainment	29
4.5 Duration of residence in Thailand	31
4.6 Occupation and duration of current employment	32
4.7 Position of work permit and residence permit	33
4.8 Salary and wages	35
4.9 Remittances to home country	35
4.10 Thai language ability	36
4.11 Domicile	37
4.12 Integration into Thai society	38

Table of Contents (con't.)

Chapter 5	Knowledge, Understanding and attitudes toward HIV/AIDS	41
	5.1 Awareness of AIDS	41
	5.2 Knowledge of HIV prevention	41
	5.3 Knowledge of routes of HIV transmission	42
	5.4 Knowledge and misunderstanding about anti-retroviral therapy (ART)	47
	5.5 Assessment of risk for contracting HIV	47
	5.6 Knowledge of an HIV VCT site and process of service	48
	5.7 Opinions about gender roles related to sex	49
	5.8 Knowledge about and access to condoms	50
Chapter 6	Knowledge of Sexually-Transmitted Infections (STI)	53
	6.1 Knowledge and understanding of STI	53
	6.2 Prevalence of self-reported symptoms of STI	54
	6.3 Outlets for STI diagnosis and treatment	55
	6.4 Preferred site for care when experiencing abnormal symptoms of the reproductive tract	55
Chapter 7	Receipt of information and knowledge about HIV/AIDS and condom use	57
	7.1 Knowledge from TV, radio and newspapers	57
	7.2 Receipt of information and knowledge about AIDS before leaving one's home country for Thailand	59
	7.3 Receipt of information and knowledge about AIDS while living in Thailand	59
	7.4 Receipt of information and knowledge about condom use	61
	7.5 Receipt of information and knowledge about voluntary counseling and testing (VCT)	62
Chapter 8	Sexual behavior and condom use	
	8.1 History of sex	65
	8.2 Age at first sex	66
	8.3 Condom use by type of partner	66
	8.4 Consistent Condom Use in the Past 12 Months	69
	8.5 Condom use at last sex by type of partner	71
	8.6 Access to condom	72
	8.7 Reasons for not using condoms	73

Table of Contents (con't.)

	Page
Chapter 9	Voluntary Counseling and Testing (VCT) 77
9.1	Knowledge of VCT outlet 77
9.2	History of visiting a VCT service 79
9.3	Counseling experience at the HIV testing service 81
9.4	Receiving the HIV blood-test results 86
Chapter 10	Family planning 87
10.1	Contraception 89
10.2	Reproductive health (RH) among female migrants
Chapter 11	Access to health services 93
11.1	Illness, injury and health-seeking behavior 94
11.2	Experience receiving care for the last episode of illness/injury 98
11.3	Special kinds of health care received 101
Chapter 12	Results of the Qualitative Evaluation 105
12.1	Structure, mechanisms and system of implementation 105
12.2	Project advocacy mechanisms 106
12.3	The mechanism of PHAMIT MHW and MHV 106
12.4	Outreach 108
12.5	Capacity building 109
12.6	Health services and access 111
12.7	Health insurance 112
12.8	Participation of stakeholders 113
Chapter 13	Summary, analysis and recommendations 115
Appendix	
A	Tables
B	Questionnaire

List of Tables

		Page
Table 2.1	Area of implementation of PHAMIT 2	5
Table 2.2	Indicators of Project impact	13
Table 2.3	Indicators of Project outcomes	14
Table 3.1	Quota and Actual Number of Sample Respondents by Province and Survey Round	20
Table 3.2	Occupation Groups of the Snowball Sample of MW	23
Table 3.3	Number of Qualitative Survey Respondents by Group	25

List of Figures

		Page
Figure 3.1	37 provinces where PHAMIT 2 was implemented area	21
Figure 3.2	11 Sample Provinces by Region	22
Figure 4.1	Mean Age by Nationality and Round	28
Figure 4.2	Marital status by round	29
Figure 4.3	Proportion of MW with No Formal Education by Nationality and Round	30
Figure 4.4	Level of Completed Education by Nationality and Round	30
Figure 4.5	Duration of Residence in Thailand by Nationality and Survey Round	31
Figure 4.6	Proportion of MW Living in Thailand for More than Five Years by Nationality and Survey Round	32
Figure 4.7	Occupation by Type and Round	33
Figure 4.8	Possession of ID and Residence Permits by Nationality and Survey Round	34
Figure 4.9	Possession of a Work Permit by Nationality and Survey Round	34
Figure 4.10	Average Daily Wage by Nationality and Survey Round	35
Figure 4.11	Proportion Remitting Funds to the Home Country by Nationality and Survey Round	36
Figure 4.12	Proportion Who Can Communicate in Thai by Mode and Round	37
Figure 4.13	Proportion participating in community activities by type and round	38
Figure 4.14	Proportion with a Thai name and ever visited Bangkok by sex and round	39

List of Figures (con't.)

	Page
Figure 5.1 Percent Knowing that Sharing Needles Can Transmit HIV by Nationality and Round	42
Figure 5.2 Percent Knowing that HIV Can Be Spread by Blood by Nationality and Round	43
Figure 5.3 Percent Knowing that HIV Cannot Be Transmitted by Sharing Meals with a PLHIV by Nationality and Round	43
Figure 5.4 Percent Knowing that HIV Can be Transmitted by an Infected Pregnant Woman to Her Fetus by Nationality and Round	44
Figure 5.5 Percent Knowing that an Infected Mother Can Transmit HIV to Her Infant by Breastfeeding by Nationality and Round	44
Figure 5.6 Percent Knowing that HIV Can Be Transmitted During Delivery by Nationality and Round	45
Figure 5.7 Percent Knowing that Person Who Looks Healthy Can Be HIV+ by Nationality and Round	45
Figure 5.8 Percent Who Believe that HIV Can Be Transmitted by Mosquito Bite by Nationality and Round	46
Figure 5.9 Percent Who Believe that HIV Can Be Transmitted by Supernatural Means by Nationality and Round	46
Figure 5.10 Percent Who Correctly Answered the 5 UNGASS AIDS Knowledge Items by Round	47
Figure 5.11 Percent Who Perceive Themselves at Risk for HIV by Nationality and Round	48
Figure 5.12 Percent Who Know/Don't Know a Nearby VCT Outlet by Nationality and Round	49
Figure 6.1 Percent Knowing of STI by Nationality and Round	54
Figure 6.2 Percent Who Would Self-treat or Not Seek Treatment for STI Symptoms by Nationality and Round	55
Figure 7.1 Proportion who watch TV daily by nationality and round	58
Figure 7.2 Frequency of Internet Usage by Nationality, 2014	59
Figure 7.3 Proportion Who Received HIV/AIDS Information by Nationality and Round	60
Figure 7.4 Proportion Receiving HIV/AIDS Information by Sex, Type of Information (Top 3) and Round	61
Figure 7.5 Proportion Receiving Information about Condoms by Sex, Nationality and Round	62
Figure 7.6 Proportion Receiving Information about VCT Services by Sex, Nationality and Round	63

List of Figures (con't.)

	Page
Figure 8.1 Percent Who Ever Had Sex by Nationality and Round	66
Figure 8.2 Percent Ever Using a Condom with their Spouse/Regular Partner by Nationality and Round	67
Figure 8.3 Percent Reporting Sex with a Non-Regular Partner in the Past 12 Months by Nationality and Round	68
Figure 8.4 Percent Who Had Sex with a Sex Worker in the Past 12 Months by Nationality and Round	69
Figure 8.5 Consistency of Condom Use with a Spouse/Regular Partner by Nationality and Round	70
Figure 8.6 Condom Use at Last Sex with a Spouse/Regular Partner by Round	71
Figure 8.7 Condom Use at Last Sex with a Non-regular Partner and Sex Worker by Nationality and Round	72
Figure 8.8 Having a Condom Available when Needed by Type of Partner, Nationality and Round	72
Figure 8.9 Percent Who Used Drugs/intoxicants Before Sex by Type of Partner, Nationality and Round	73
Figure 8.10 Percent Who Feel that Condoms Reduce Pleasure of Sex by Type of Partner, Nationality and Round	74
Figure 8.11 Confidence in Ability to Negotiate Condom Use with Spouse/Regular Partner by Nationality and Round	74
Figure 8.12 Condom Use Negotiation by Strategy, Sex, Nationality and Round	75
Figure 9.1 Percent Who Know a VCT Outlet by Sex, Nationality and Round	78
Figure 9.2 Types of VCT Cited in 2014 by Nationality	79
Figure 9.3 Percent Ever Being Tested for HIV by Nationality, Sex and Round	80
Figure 9.4 Type of VCT Outlet in 2014 by Nationality and Sex	80
Figure 9.5 Reason for VCT by Nationality, Sex and Round	81
Figure 9.6 Percent Who Received Pre- or Post-Test Counseling During HIV-testing Service by Nationality and Round	82
Figure 9.7 Content of Pre-test Counseling by Nationality and Round	83
Figure 9.8 Content of Post-test Counseling by Nationality and Round	84
Figure 9.9 Language Used During the Counseling Session by Nationality and Round	85
Figure 9.10 Percent Receiving Results of HIV Test by Nationality, Round and Accompanying Person	86

List of Figures (con't.)

	Page
Figure 10.1 Top 3 Methods of Modern Contraception Known Nationality and Round	88
Figure 10.2 Top 3 Methods of Modern Contraception Known Nationality and Round	88
Figure 10.3 Method of Contraception Currently Used (Top 3) by Nationality and Round	89
Figure 11.1 Percent of MW Who Had an Illness/Injury Requiring Clinical Care in the Past 12 Months by Nationality, Sex and Round	94
Figure 11.2 Decision to Seek Health Care by Type of Outlet by Nationality and Round	94
Figure 11.3 Reasons for Not Seeking Care at a Government Hospital by Nationality and Round	95
Figure 11.4 Reasons for Not Seeking Health Care at a Private Hospital by Nationality and Round	96
Figure 11.5 Reason for Not Seeking Health Care at a Private Clinic by Nationality and Round	97
Figure 11.6 Reason for Not Seeking Care at a Health Center by Nationality and Round	97
Figure 11.7 Type of Health Care Outlet Visited at Last Episode of Illness/injury by Nationality and Round	98
Figure 11.8 Satisfaction of Service by Public and Private Outlet and Nationality, 2014	99
Figure 11.9 Type of Person Who Assisted in Accessing Health Care by Nationality, 2014	100
Figure 11.10 Type of Assistance Received in Seeking Health Care by Nationality, 2014	100
Figure 11.11 Received STI Case Management by Nationality, 2014	102
Figure 11.12 Received Condom Distribution by Nationality, 2014	102
Figure 11.13 Health Insurance Coverage by Nationality, 2014	103
Figure 13.1 Mechanisms of Field implementation	128

Abbreviations

CHAMPION	The Comprehensive HIV Prevention among MARPS by Promoting Integrated Outreach and Networking Program
DiCs	Drop in Centers
FAR	Foundation for AIDS Rights
FSW	Female Sex Worker
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
IDU	Inject drug user
JSMC	Joint Strategic Management Committee
KAP	Knowledge Attitude Practice
LAO	Local administrative organization
MAP	Migrant Assistance Programme Foundation (MAP Foundation)
MARPS	Most at Risk Populations
MHV	Migrant Health Volunteer
MHW	Migrant Health Worker
MSM	Men who have sex with men
MW	Migrant Worker
NGO	Non-Government Organization
NAMc	National AIDS Management Center
PCM	Provincial Coordinating Mechanism
PR	Principle Recipient
PR-DDC	PR-Department of Diseases Control
PHAMIT	Prevention of HIV/AIDS Among Migrant Worker in Thailand
RCC	Rolling Continuation Channel
RFT	Raks Thai Foundation
SSF	Single Stream Funding
SR	Sub Recipient
SSR	Sub-Sub Recipient
STI	Sexually Transmitted Infections
UNGASS	United Nation General Assembly Special Session
VCT	Voluntary Counseling Testing
VHV	Village Health Volunteer
WHO	World Health Organization
WVFT	World Vision Foundation Thailand

1

Introduction

1.1 Background and Rationale

The PHAMIT 2 Project is part of a larger, umbrella program funded by the GFATM called CHAMPION or “The Comprehensive HIV Prevention among MARPS by Promoting Integrated Outreach and Networking Program.” CHAMPION directed interventions to four vulnerable populations: Female sex workers (FSW), men who have sex with men (MSM), persons who inject drugs (PWID) and cross-border migrant workers (MW). The Raks Thai Foundation (RTF) was appointed as the Principal Recipient to manage the project for MW, known as PHAMIT 2. RTF had eight collaborating partners for the Project including World Vision Foundation (Thailand), the Foundation for AIDS Rights (FAR), the Pattanarak Foundation, the Stella Maris Seafarers Center, the AIDS Network Development Foundation, the MAP Foundation, the Social Development Association, and the Bureau of Health Administration of the Ministry of Public Health (MOPH). The RTF and these agencies developed a program of interventions to extend HIV prevention information and services to MW working in Thailand from Myanmar, Cambodia and Lao PDR who may have had risk behavior for HIV. The Project included community outreach and creation of integrated networks of migrant-friendly services, implemented over a five-year period from 2009-2014.

PHAMIT 2 is a continuation of PHAMIT 1 which was implemented during 2004-2008 with the goal of reducing new HIV infections by maximizing coverage of accessible prevention services in high priority provinces and sub-groups of MW with the highest risk for HIV. There are three overall objectives of PHAMIT 2: (1) To strengthen and expand integrated prevention of HIV for MW at risk of HIV; (2) To create an enabling environment for HIV prevention with equal and sustainable access for MW with risk for HIV; and (3) To strengthen the strategic information system to promote improvements in policy and programs for high risk populations.

Thus, this evaluation of the PHAMIT 2 Project is an essential part of assessing the lessons learned and achievements of the Project. To ensure objectivity, an external agency was contracted to conduct this evaluation: The Institute for Population and Social Research of Mahidol University. The results from the 2014 evaluation survey were compared with the baseline measures conducted at the beginning of PHAMIT 2 in 2010.

The evaluation team collected both quantitative and qualitative data to examine the experience of those MW exposed to the Project interventions, as well as those who did not participate in the activities. The evaluation examined the extent of implementation by collaborating partners, stakeholders and the local community, and assessed outputs and outcomes against the Project targets and objectives. The data collection staff communicated in the language of the MW respondents when conducting interviews to ensure comprehension of the questions, accurate recording of responses, and to build rapport.

The evaluation team hopes that the results from this study are of benefit to the implementing partners and others who are involved in sustaining the successful components of PHAMIT 2 in the years ahead.

1.2 Components of Project planning, monitoring, control, and evaluation

The follow-up evaluation survey of 2014 is just one component of the overall Project evaluation effort, which includes the following other key activities:

- The PHAMIT 2 baseline survey of 2010;
- The midterm Project evaluation survey conducted in 2012; and
- The Project impact survey of 2014.

Objectives

1. To assess the achievements of the Project in terms of outputs, outcomes and impact on the reproductive health (RH) of the MW;
2. To assess the efficiency, effectiveness, sustainability and role of the Project in improving public policy toward extending client-friendly health services for MW in Thailand;
3. To distill the lessons learned from the Project as a basis for planning and improving implementation in the future.

The 2014 evaluation survey results were compared against the findings of the 2010 baseline and 2012 midterm surveys to provide a time series to better attribute improvements in the indicators to Project interventions. The 2014 evaluation was conducted over an 8-month period from October 2013 to May 2014.

2

Background of PHAMIT 2 and Review of the Findings from the 2010 Baseline Survey

2.1 Background of PHAMIT 2

PHAMIT 2 is a part of the umbrella program called CHAMPION, funded by the GFATM. CHAMPION was intended to assist the Thai government's National AIDS Program (NAP) in extending coverage of HIV prevention services to the more vulnerable members of society who also might have more difficulty accessing health services than the mainstream population. Civil Society organizations were key implementing partners of CHAMPION because of their history of work with the more vulnerable groups (e.g., MSM, FSW, PWID and MW). The Principal Recipients of GF assistance include the RTF (for PHAMIT 2, targeting MW and their accompanying dependents), the Department of Disease Control (DDC, for prevention for MSM and FSW), and PSI Foundation (for interventions with PWID).

2.2 Goal, Objectives and Target Groups

The goal of PHAMIT 2 is the reduction of new HIV infections by maximizing coverage of accessible prevention services in high priority provinces and sub-groups of MW with the highest risk for HIV. There are three overall objectives of PHAMIT 2: (1) To strengthen and expand integrated prevention of HIV for MW at risk of HIV; (2) To create an enabling environment for HIV prevention with equal and sustainable access for MW with risk for HIV; and (3) To strengthen the strategic information system to promote improvements in policy and programs for high risk populations.

In the first phase of PHAMIT 2, the Project focused on 115 districts in 34 priority provinces of the NAP which had large concentrations of MW age 15-49 years. The composition of the migrant population in these locations was 80% Burmese, and 10% each for Cambodian and Lao. The principal occupations of the MW include the following:

- Fisheries and fishing boat crew
- Seafood processing
- Factories
- Construction
- Agro-industry

The predecessor Project, PHAMIT 1, focused on 18 provinces which had coastal sea borders with neighboring countries, and the target population was MW working in fisheries and seafood processing. PHAMIT 2 continued interventions in the PHAMIT 1 provinces and added 14 more provinces which also had significant numbers of MW in other occupations besides fisheries. In its first two years, PHAMIT 2 established a target of 249,844 MW to be reached with HIV prevention information and services. PHAMIT 2 also assisted accompanying dependents of the MW and provided development inputs to the MW residential communities. To reach the MW in the worksite, PHAMIT 2 had to forge collaborative relationships with employers of MW and, to link with the MW with needed services, PHAMIT 2 had to develop referral systems with local health service providers and government agencies. An enabling environment for HIV prevention for MW was strengthening by use of mass media and various campaigns.

2.3 Area of implementation

Table 2.1 shows the areas of PHAMIT 2 implementation of 122 districts in 37 provinces. Initially, ten provinces were identified to serve as pilot project locations for refining client-friendly services for MW. These ten provinces are Chonburi, Rayong, Samut Sakorn, Samut Prakan, Tak, Chiang Mai, Pattani, Ranong, Songkhla, and Phuket.

2.4 Project strategy

The Project planned to expand coverage of HIV prevention by increasing access to client-friendly services for 249,844 MW and dependents in the first two years of implementation. This required the expansion of collaboration among Civil Society and participation by the affected communities themselves. At the same time, PHAMIT 2 served as the link between MW and the public health service system. To that end, the Project conducted capacity building for health staff in providing services for MW. The Project also advocated for improved policies with senior level managers and policy makers in the hope that the successful Project interventions would be sustained

and absorbed into the routine service system to achieve sustainability. Mass media was engaged to help reduce stigma and negative prejudice against MW.

Table 2.1: PHAMIT 2 Areas of Implementation

	Province	No. districts	District	Implementing partners
Central Region				
1	Bangkok	3	Minburi, Nong Jawk, Lat Krabang	FAR
2	Nontaburi	3	Muang, Pakkred, Nong Bua Tong	WVFT
3	Samut Prakan	3	Muang, Bang Bo, Bang Pli	RTF
4	Samut Songkram	1	Muang	RTF
5	Samut Sakorn	3	Muang, Kratum Ban, Bang Phaew	RTF
6	Pathum Thani	1	Khlong Luang	WVFT
Eastern Region				
7	Chonburi	4	Muang, Sattahip, Banglamung, Sriracha	FAR
8	Trad	4	Muang, Laem Ngop, Khlong Yai, Koh Chang	RTF
9	Rayong	4	Muang, Klaeng, Pluak Daeng, Ban Khai	FAR
10	Chantaburi	2	Tha Mai, Laem Sing	RTF
Western Region				
11	Kanchanburi	4	Muang, Sangklaburi, Tha Muang, Tha Maka	Pattanak Foundation
12	Prachuap Kirikan	4	Muang, Pranburi, Kuiburi, Bang Saphan	RTF
13	Ratchaburi	3	Muang, Ban Pong, Potharam	Pattanak Foundation

	Province	No. districts	District	Implementing partners
	North Region			
14	Chiang Rai	6	Muang, Mae Jan, Mae Sai, Mae Fah Luang, Chiang Saen, Chiang Kong	WVFT
15	Chiang Mai	8	Muang, Hang Dong, Sarapi, Sansai, Doi Saket, Mae Rim, Sankampaeng, Chiang Dao	MAP Foundation
16	Tak	3.5	Mae Sot, Pope Phra, Tha Song Yang, Mae Ramat	WVFT
		0.5	Mae Tao Mai (Mae Sot)	MAP Foundation
Northeast Region				
17	Khon Kaen	3	Muang, Nong Reua, Nam Pong	AIDS Network Development Foundation
18	Nakorn Panom	4	Muang, That Panom, Ban Paeng, Tha U-then	AIDS Network Development Foundation
19	Nakorn Ratchasima	4	Muang, Pak Chong, Sung Nern, Sikiw	Social Development Association
20	Mukdaharn	4	Muang, Don Tan, Wan, Dong Luang	RTF
21	Loei	4	Muang,Chiang Khan, Tha Li, Pak Chom	RTF
22	Srisaket	1	Muang, Kantaralak, Khunhan	RTF

	Province	No. districts	District	Implementing partners
23	Nongkhai	4	Muang, Tha Bo, Ratawapi, Ponpisai	AIDS Network Development Foundation
24	Beungkan	1	Muang	AIDS Network Development Foundation
25	Udon Thani	4	Muang, Ban Peur, Kumpawapee, Nayung	RTF
26	Ubon Ratchatani	6	Khong Jiam, Sirintorn, Khemarat, Buntarik, Pibul Mangsaharn, Natan	RTF
Southern Region				
27	Krabi	4	Muang, Khlong Thom, Neua Khlong, Lanta	WVFT
28	Chumporn	3	Muang, Lang Suan, Tha Sae	WVFT
29	Trang	4	Muang, Kantang, Sikao, Yantakhao	RTF
30	Nakorn Si Tammarat	3	Kanom, Sichon, Thung Song	RTF
31	Pattani	1	Muang	RTF
32	Phang Nga	3	Thai Muang, Takuapa, Kuraburi	WVFT
33	Phuket	3	Muang, Krathu, Klang	WVFT
34	Ranong	2	Muang, Kraburi	WVFT
35	Songkhla	2	Muang, Hat Yai	Stella Maris Seafarers Center
36	Satun	2	Muang, Langu	Stella Maris Seafarers Center
37	Surat Thani	3	Muang, Phunpin, Wiang Sa	RTF
	Total	122		

Key intervention strategies include reduced risk behavior, HIV VCT, condom distribution, and referral for STI diagnosis and treatment. Interventions were tailored to suit the culture and needs of the MW. The strategic information system was strengthened to help with monitoring progress and change in the Project indicators.

2.5 Implementation activities

Objective 1: To strengthen and expand integrated prevention of HIV for MW at risk of HIV

Activity 1.1: Behavior change interventions: Accessing the community

1.1.1 Recruitment and training of field staff and peer educators

Communication difficulties for MW in Thailand are a formidable barrier to accessing health services. Thus, the Project gave emphasis to recruiting and training bi-lingual Migrant Health Workers (MHW) to serve as a bridge between the MW client and Thai health provider. These MHW also helped create a client-friendly atmosphere for the MW and helped to ensure that their needs were addressed. Thai health staff were given orientation and training by the Project to help them understand the MW client population better and to provide a more culturally-sensitive service.

1.1.2. Behavior change activities for the higher risk groups

The project developed and delivered a variety of multi-lingual educational and motivational media to reach the higher-risk populations through community outreach, drop-in centers, entertainment establishments, VCT clinics, STI clinics, pharmacies, ART clinics, radio, newspapers, pamphlets, leaflets, video, and Internet websites. Content was modified to be culturally appropriate, and basic language was used for easier comprehension.

1.1.3 Strengthening channels of access to MW with risk for HIV, including drop-in centers (DiC)

The Project established DiC in 36 of the target provinces to increase access to and for the community of migrants, improve rapport between the Project staff and the MW and as a base of outreach activities. The DiC also had peer educators available to conduct individual and group activities. The DiC came to be seen as a safe space for MW to congregate and share experience and news. This helped to build networks of the MW and expand the social relationships among them and with the Project. DiC were linked with community health posts for cross-referral.

Activity 1.2: Condom distribution and needle exchange**1.2.1 Free condom distribution**

MW could obtain free condom supplies from the Project's DiC and information centers. In addition, field coordinators and peer educators provided condom resupply during outreach, and MW could also obtain resupply from condom dispensers installed in their worksites, shops, and other points of convenient access.

Activity 1.3 HIV, VCT**1.3.1 Increased number of VCT outlets which are client-friendly for the MW**

Government health staff at public hospitals and health outlets provide VCT services to the general population, including non-Thai migrants. To increase coverage, the Project supported a mobile VCT service in association with the community information centers and DiC. Bi-lingual counselors were mobilized to enhance the counseling experience for MW and ensure that the service was client-friendly.

1.3.2 Follow-up of MW testing positive for HIV: Positive prevention

MW testing positive for HIV needed to be monitored in case they met the criteria for starting ART. The MHW played a crucial role in tracking and maintaining contact with the HIV+ migrants through a system of monthly appointments, home visits, and positive prevention activities in collaboration with health staff, Project field coordinators and DiC staff and volunteers.

Activity 1.4 Diagnosis and treatment of STI**1.4.1 Strengthening the referral system for STI case management**

The Project increased access for MW to STI services through outreach and referral, largely with the help of Civil Society and NGO groups with links to hospitals and clinics. Field staff, staff of the community information centers and DiC were trained in referral for STI. Only registered MW had annual physical exams and STI screening and treatment as part of their compulsory health insurance coverage. Thus, the Project focus was on the unregistered MW to increase coverage and reduce duplication with the MOPH program.

Activity 1.5 Strengthening the health care system for MW

1.5.1 Improving the training for health care providers

Project efforts to build the capacity of health staff, mostly in the public sector, involved collaboration with the DDC, Department of Health Promotion, and the Department of Medical Services of the MOPH. The focus was on helping the staff to better understand the circumstances, environment and needs of cross-border migrants, and the components of client-friendly services.

1.5.2 Training and creating a sense of collaboration among the health staff

Health care providers who were in a position to encounter MW clients at STI or VCT clinics were trained by the MOPH on appropriate interactions with MW and working through interpreters.

Objective 2: To create an enabling environment for HIV prevention with equal and sustainable access for MW with risk for HIV

Activity 2.1: Enabling environment: Strengthening Civil Society and organizational capacity building

2.1.1 Building capacity of individuals from higher-risk groups to serve as representatives at HIV forums and meetings

MW and their networks were trained for greater self-reliance in addressing their needs and establishing links with relevant groups and services to improve the daily life of the migrant community. This included establishing links with networks of PLHIV support groups and labor unions.

2.1.2 Promoting convenient access to health and social services to address problems of sexual violence among risk populations, especially the sexually diverse

This activity strengthened the referral network for health and social services. The community information centers, DiCs and field staff helped increased MW awareness of RH standards and service guidelines. The FAR NGO was a key player in helping education MW about dealing with sexual violence, rights violations against women, and protections for those with sexually diverse lifestyles.

Activity 2.2 Promoting an enabling environment through policy and legal reform

2.2.1 Review and support for improving policy and law related to risk populations, such as reducing vulnerability of PWID and providing health insurance for MW

Two issues which the Project addressed include increasing coverage options for health insurance for MW, and institutionalizing the MHW. The Project lobbied senior managers and policy makers to help advocate for these improvements. As an interim measure, support funds were established to help provide job security for MHW, until the Ministry of Labor (MOL) could find a way to create a formal position. This is being considered by the Office of Foreign Workers Administration, which has representatives from the MOPH, MOL, and National Security Council.

2.2.2 Technical assistance to local agencies, employers, and government staff to improve policy and resource allocation for HIV/AIDS

The Provincial Coordinating Mechanism (PCM) was established under the GF 1-RCC round as the coordination nexus for AIDS activities in the province, and to produce joint plans for interventions for vulnerable populations, including MW. The plans form the basis for resource mobilization and collaboration in implementation. MW and their employers were trained to identify policy gaps and opportunities for improving health and safety in the workplace, including HIV prevention in the locality.

Activity 2.3 Reducing stigma and promoting human rights

2.3.1 Workshop for collaboration with mass media as a motivational force for health and human rights of persons with risk for HIV

This workshop helped to sensitize representatives of mass media, local agencies and personnel about the rights and needs of MW. One theme was to use mass media to expose awareness of stigma, discrimination and rights violations of MW. The goal was to increase the amount and frequency of mass media coverage of issues which MW face.

2.3.2 Training of police, corrections officers and other law enforcement personnel on supporting services for high-risk populations

This training included lawyers, law enforcement personnel and related staff to explore ways to support, or at least not hinder, Project interventions with MW.

2.3.3 Participation in national and international forums to increase public Awareness

Project partners arranged or participated in national forums to ensure that mass media was aware of and covered issues related to MW in Thailand, and increased concern about HIV, understanding and acceptance of MW.

Objective 3: To strengthen the strategic information system to promote improvements in policy and programs for high risk populations.

Activity 3.1 Strengthening the health information and surveillance systems

3.1.1 Improving health information and surveillance systems and training Project partners in efficient management practices for improved Implementation

This activity was conducted to produce more outcome and impact data for the Project and strengthening the 2nd general surveillance system, and the health management information system. This included training in in-depth analysis and creating data linkages with the policy process.

3.1.2 Capacity building for implementing partners, community organizations and health service outlets in monitoring quality of Project activities and using data to help improve implementation

This involved training in the collection and use of essential data to inform improvements to Project implementation at the service site and community. The PCM was the key counterpart in this activity. The Project developed tools to help with data collection and mapping of MW access points and estimates of the size of the population of MW. This support included activity monitoring forms for assessing coverage and quality of services. A cadre of mentors was recruited and trained to provide backup in monitoring and evaluation (M&E) and targeting. The Project encouraged evidenced-based decision making at all levels. Annual progress review seminars and lessons learned forums were convened for sharing and distilling Project achievements and challenges.

Activity 3.2 Action research

3.2.1 Implementation of applied research

- Estimates of the size of the populations of hidden populations using social networking and respondent-driven sampling with support from UNAIDS and WHO.
- Assessment of sustainability of HIV prevention interventions for higher-risk populations, based on a cost-effectiveness analysis.
- Study of models of financial support for covering unregistered MW with health insurance;
- Cost-effectiveness analysis of health services for MW.

Reports of these and other studies were disseminated widely and can be accessed at www.phamit.org.

2.6 Overview of Project indicators

1) Impact

Table 2.2: Project Impact Indicators

Indicator	Target by Project Year				
	1 2009	2 2010	3 2011	4 2012	5 2013
% of migrant workers who are HIV infected	Baseline established for 10 sentinel provinces	-	2.24%	-	1.96%

2) Outcome

Table 2.3 Project Outcome Indicators

Indicator	Target by Project Year				
	1	2	3	4	5
% of migrant workers reporting the use of a condom the last time they had sexual intercourse with a non-regular partner	Baseline established through KAP survey and IBBS	-	TBD	-	TBD

3) Outputs

Indicators are presented by Project objective and activity.

Objective 1:

Activity 1.1 Communication for behavior change

Indicator 1.1: Number of MW receiving HIV prevention services

Indicator 1.2: Number of persons receiving training in HIV prevention for MW

Activity 1.2: Distribution of prevention supplies

Indicator 1.3: Number of free condoms distributed to MW

Activity 1.3: VCT

Indicator 1.4: Number of MW who had VCT in the past 6 months and know the results

Activity 1.4: STI case management

Indicator 1.5: Number of MW who received STI case management

Objective 2

Activity 2.1: Strengthening the health service system

Indicator 2.1: Number of government health staff trained in client-friendly services for MW

Activity 2.2: Strengthening Civil Society and local organizations

Indicator 2.2: Number of service providers in Civil Society, NGOs and local organizations trained in gender issues and high-risk populations

Activity 2.3: Improving the legal and policy environment

Indicator 2.3: Number of staff of local administrative organizations trained in policy and resource mobilization

Activity 2.4: Promoting human rights and eliminating prejudice

Indicator 2.4: Number of stakeholders receiving training in being open and accepting of others

2.7 Duration of Project implementation

- 1) Phase 1: June 2009 – May 2011
- 2) Phase 2: June 2011 – May 2014

2.8 Review of the findings of the 2010 Baseline Survey**2.8.1 Receipt of information and services by the MW****2.8.1.1 Receipt of health information**

The Baseline Survey for PHAMIT 2 was conducted in 11 provinces in 2010 among 3,405 MW respondents. Most MW had received information about HIV/AIDS after arriving in Thailand during campaigns or orientation sessions. More Cambodian MW participated in these orientations, while MW from Myanmar had the least exposure. Most of the information the MW received was about STI, HIV infection, and interacting with PLHIV. Four out of five of the sample had received HIV prevention information and over half received information about STI. About one-third received information about interacting with PLHIV, and one-fourth received information about how to care for oneself if infected. The MW from Myanmar received the most information about HIV prevention followed by STI, and interacting with PLHIV. The Lao MW received most information about STI, followed by HIV prevention. Most of the information was delivered by RTF, WVFT, the Pattanarak Foundation and AIDS ACCESS.

The Migrant Health Volunteers (MHV) had the biggest role in the Project of disseminating information on all topics related to HIV/AIDS to the MW from Myanmar and Cambodia. By contrast, health care providers were the most important source of information about HIV/AIDS for Lao MW. Most of the sample of MW had received information about condoms and were quite knowledgeable about condoms, especially the Lao MW. More male than female MW had received information about condoms and had higher knowledge levels on this topic. The most important source of

information on condoms was from focus group discussion, followed by training or lectures, brochures, booklets, or posters. More of the Myanmar MW received information from casual conversation, while the Lao and Cambodian MW mostly received this information from training events.

NGO clinics were an important source of Project information, including information about condoms and VCT, especially for MW from Myanmar and Cambodia. Common channels for receiving information about VCT was either through focus group discussion, print material, or booklets for Burmese MW. However Cambodian and Lao MW mostly received this information via training or lectures. Barriers to VCT uptake for MW include lack of correct knowledge about illness, and lack of access to formal public health services in general.

2.2.2 Access to health services for MW

Access to basic health care is a universal human right, regardless of nationality or legal status. The MW in Thailand in 2010 faced various obstacles to accessing health such as lack of money to pay the treatment cost, lack of proper identification, lack of a work permit, or not being registered. Most of the MW in the Baseline Survey (80%) preferred to go to a government hospital when injured or ill, especially those from Myanmar and Cambodia. Secondary sources of care include health centers and private clinics. The Lao MW preferred private clinics to government outlets. Reasons for *not* going to a government hospital include: (1) Lack of an ID card; (2) Symptoms or condition not severe – prefer to self-treat; (3) Long wait times; (4) Remote location; and (5) Lack of health insurance. Reasons for not going to a health center include lack of knowledge about function or location, remoteness, and lack of an ID card. Reasons for not going to a private hospital or clinic when sick include high cost of care, and lack of familiarity with private outlets.

Most MW in this sample were very satisfied with the care they received at Thai government outlets. They were also highly satisfied with the convenience of accessing care. The MW from Myanmar had the highest levels of satisfaction with public health services among the three nationalities. Those who had used private clinics or hospitals were also satisfied with the service and felt it was convenient, but at lower levels than for the government outlets. Important obstacles to seeking care include lack of fluency in Thai, lack of understanding of the process of care, household responsibilities (e.g., have to stay at home to care for an infant) and lack of confidence in going to a clinic or hospital. For MW from Myanmar, having a co-worker assist them was an important factor in seeking health care. A spouse and the MHW were also important sources of assistance in seeking care, as well as employers. For Cambodian MW, a co-worker, employer, spouse, or co-habiting acquaintance were important in providing assistance in seeking health care. Half of the Lao MW were assisted by a spouse when seeking care, followed by a friend, or employer. Assistance for the MW included directions to

the outlet, explanation of the procedures, helping as an interpreter, or assisting with the travel cost.

2.2.3 Specific health care needs of the MW

Health care services which need to be modified or tailored to the special needs of the MW include referral, STI counseling for diagnosis and treatment, VCT, orientation of labor rights protection and prevention of STI. Most of the MW from Myanmar sought STI services from a Project-affiliated NGO clinic, followed by a government hospital. For HIV counseling, legal/rights assistance, or free condom resupply, most MW preferred a Project partner NGO clinic as the first stop.

Cambodian MW also sought STI care or counseling from Project NGO clinics as a first stop. But very few Cambodian MW received VCT or legal assistance services. They sought free condom resupply from NGO clinics as well.

Very few Lao MW sought STI care, VCT or legal/rights assistance. Most Lao MW who received condoms obtained them from Project-affiliated NGO clinics, followed by government hospitals or health centers.

3

Methodology of the Evaluation Survey

Target Population

For this Project impact evaluation, the survey team collected both quantitative and qualitative data from male and female MW, age 15-59 years, from Myanmar, Cambodia and Lao PDR who had been in Thailand at least three months. The sample includes both registered and unregistered MW working in the fisheries industry, factories, construction or agro-industry. In-depth information was collected from public and private health service providers in the Project locations, MHW, MHV, employment offices, local administrative organizations (LAO), business associations, chambers of commerce, human resources staff of the employers of MW, and community leaders and VHV.

3.1 Quantitative Survey

3.1.1 Sample size and selection of sample sites

The quantitative evaluation survey had a prescribed sample of 3,600 MW in 11 provinces out of the 37 provinces where the Project was implemented. The provinces were selected purposively to be consistent with the locations of the 2010 Baseline Survey. Six provinces had large concentrations of MW from Myanmar; two provinces had communities of Cambodian MW; and three provinces had a relatively large number of Lao MW. Yamane's Formula was used to determine a quota sample of 400 respondents per province for Cambodian and Burmese MW, while 400 Lao MW were selected from three provinces. The following provides more detail on the steps in the sampling process.

1. The 37 provinces were stratified by nationality of the majority population of MW;
2. Then, eleven provinces were purposively selected to include a range of geographic areas;
3. Yamane's Formula prescribed an appropriate quota sample of between 250 to 400 MW per province. However, as noted, three provinces were combined as the sample unit for the Lao MW due to less dense concentration of this population.

The formula for sample size calculation is as follows:

$$n = \frac{N}{1 + Ne^2}$$

when n = sample size
 N = population size
 e^2 = measure of variance

A statistical confidence level was set at 95%. Table 3.1 compares the actual number of sample respondents by province and survey round.

Table 3.1: Quota and Actual Number of Sample Respondents by Province and Survey Round

Province	Sample size based on Yamane's Formula	Actual sample size: Baseline Survey 2010	Actual sample size: Follow-up Survey 2014
Provinces with a majority of MW from Myanmar			
Bangkok	400	224	404
Samut Prakan	400	398	400
Samut Sakorn	400	375	404
Ranong	400	401	402
Tak	400	380	403
Surat Thani	400	391	411
Total	2,400	2,169	2,424
Provinces with a majority of MW from Cambodia			
Trad	400	399	406
Rayong	400	400	402
Total	800	799	808
Provinces with a majority of MW from Lao PDR			
Ubon Ratchathani	400	437	324
Nongkhai			
Khon Kaen			
Grand Total	3,600	3,405	3,555

Remarks: (1) The reason the number of interviewed Lao MW is less than the quota is due to deviation in estimates of the total population of Lao in the three provinces. The Project partners had estimated a larger population of MW than were present at the time of the evaluation survey field work, since the field work period coincided with the months when many Lao MW returned home for temporary visits. Also, some employers restricted access to their MW employees. (2) Due to high mobility and lack of access to some groups of MW in Bangkok, the sampling area was extended to suburban areas of Bangkok that overlapped with Nonthaburi Province, in order to attain the prescribed sample quota.

Figure 3.1 : 37 Provinces where the PHAMIT-2 implementation area**Central**

1. Bangkok
2. Nonthaburi
3. Samut Prakan
4. Samut Songkram
5. Samut Sakorn
6. Pathum Thani

Eastern

7. Cholburi
8. Trad
9. Rayong
10. Chanthaburi

Western

11. Kanchanaburi
12. Prachuap
13. Ratchaburi

North

14. Chiang Rai
15. Chiang Mai
16. Tak

Northeast

17. Khon Kaen
18. Nakorn Panom
19. Nakornratchasima
20. Mukdahan
21. Loei
22. Sisaket
23. Nongkhai
24. Udonthani
25. Ubonratchathani
26. Bungkan

Southern

27. Krabi
28. Chumporn
29. Trang
30. Nakorn Si Tammarat
31. Pattani
32. Phang Nga
33. Phuket
34. Ranong
35. Songkhla
36. Satun
37. Surat Thani

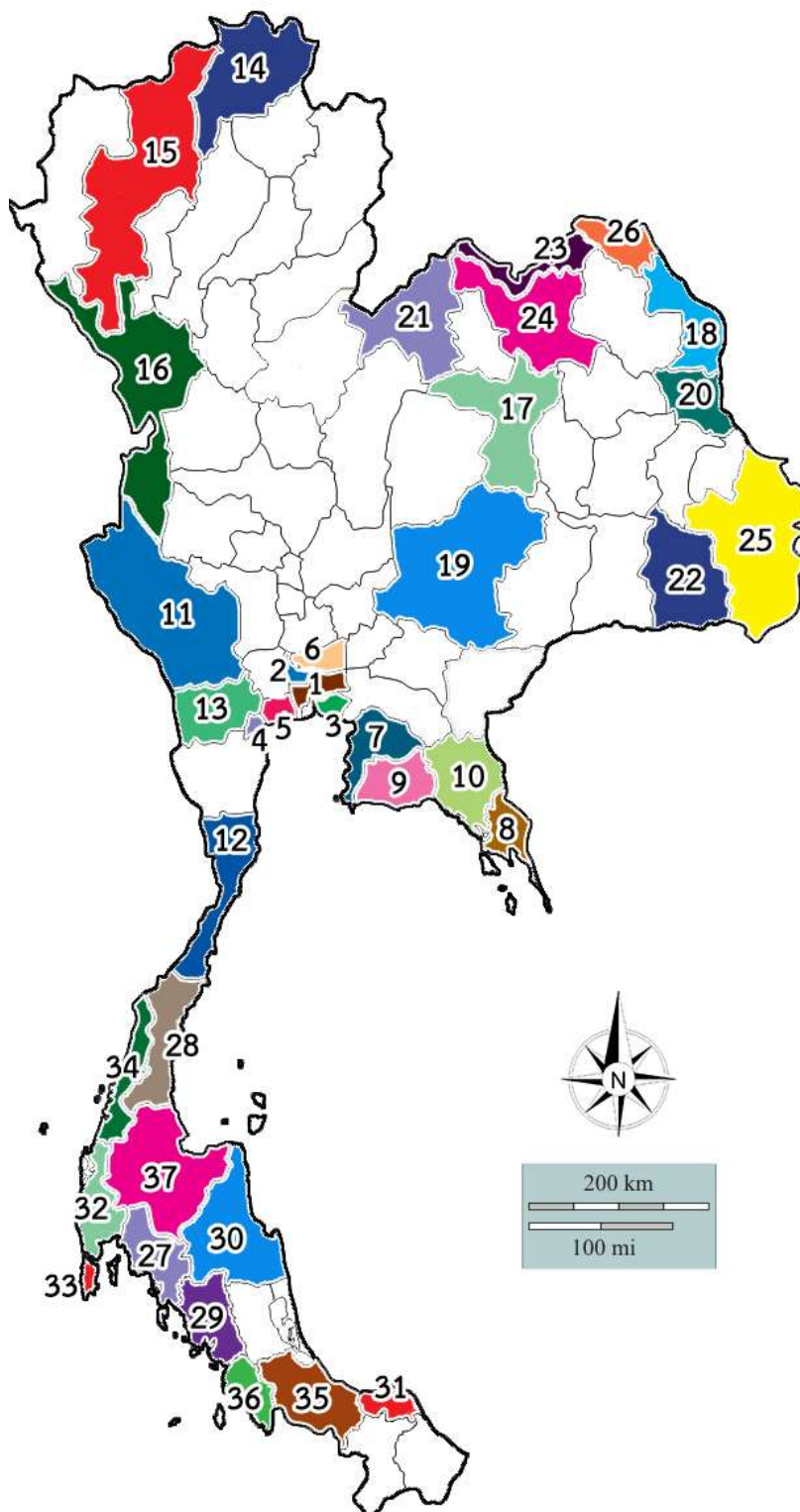


Figure 3.2 : 11 Sample Provinces by Region**North**

1. Tak

Central

2. Bangkok

3. Samut Sakorn

4. Samut Prakan

East

5. Rayong

6. Trad

Northeast

7. Ubon Ratchatani

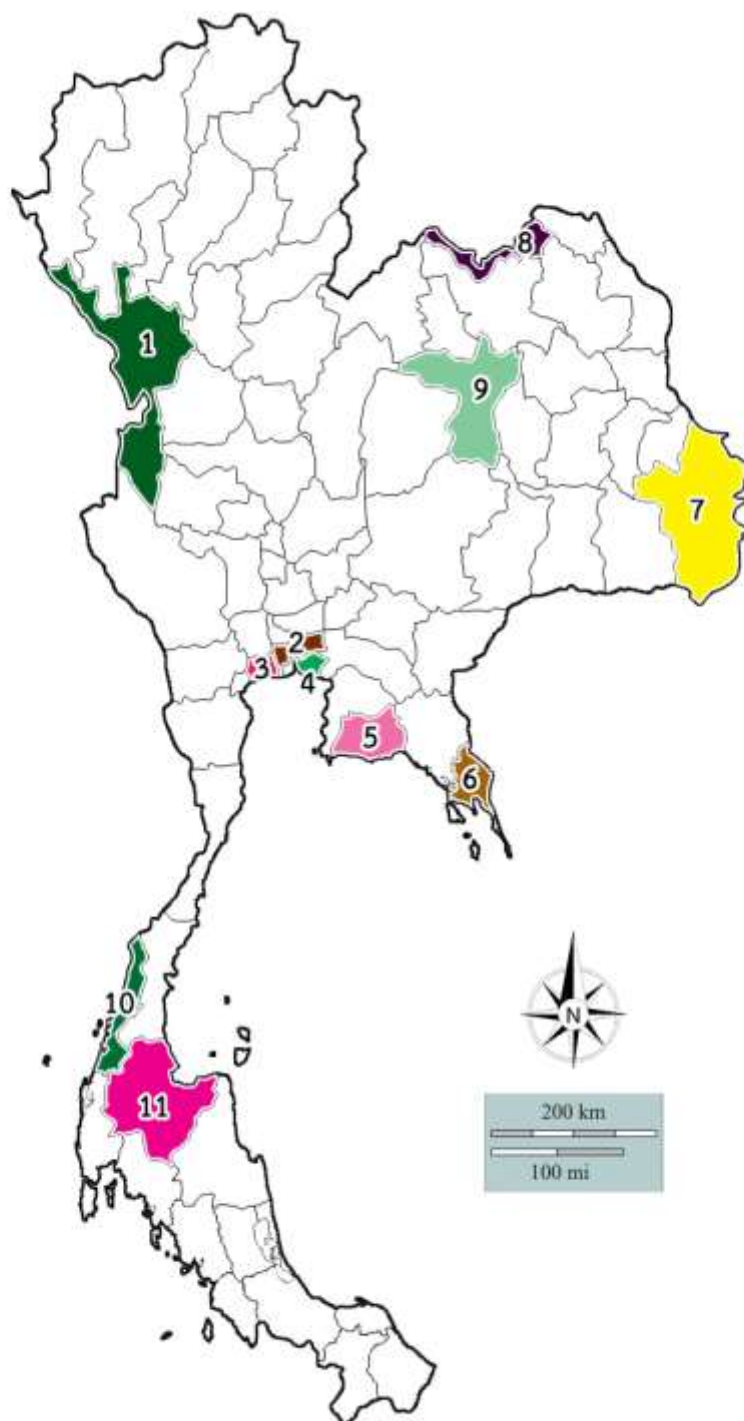
8. Nongkhai

9. Khon Kaen

South

10. Ranong

11. Surat Thani



4. Because many of the MW in Thailand are unregistered (i.e., illegal) there is no accurate list of the number of MW in a given province or district. Thus, the evaluation team used snowball sampling and a chain-referral (seed and seed contacts) method to attain the prescribed number of respondents. Attempts were made to distribute the initial site locations to fully represent the diversity of the MW population in a given district or Tambon (sub-district) of the eleven provinces. Table 3.2 displays a model of how this was done.

Table 3.2: Occupation Groups of the Snowball Sample of MW

PHAMIT area of implementation in a given province	Occupation Group			Total	%	Number of seed respondents
	Fisheries	Seafood processing	Construction			
District A						
Tambon 1	10,000 (8)	4,000 (3)	2,000 (2)	16,000	33	13
Tambon 2	6,000 (6)	2,000 (2)	1,000 (1)	9,000	21	9
District B						
Tambon 1	4,500 (4)	3,500 (3)	1,000 (1)	9,000	19	8
Tambon 2	3,000 (3)	1,500 (1)	500 (-)	5,000	10	4
Tambon 3	3,500 (3)	500 (-)	-	4,000	8	3
Tambon 4	2,000 (2)	1,000 (0.5)	1,000 (0.5)	4,000	8	3
Total				48,000	100	40

Remarks: 1. The number in () is the number of seed respondents;
2. Approximately 40 locations in a province were selected to begin the snowball sampling, which was intended to yield an average of 10 respondents in the chain.

The sample was constructed to allow disaggregated analysis of each province (except for the sample of Lao MW), as well as the overall combined sample for analysis by region and occupation group. Further, fractional weights were assigned to each province proportional to the estimated total number of MW in the province, to provide weighted measures of variables for the combined sample.

3.1.3 Survey instruments

For the quantitative data collection, structured questionnaires were administered by interviewers in one of four languages: Thai, English, Burmese, Lao and Khmer. The content include general information of the respondent, knowledge and behavior related to the UNGASS and GFATM indicators, and other information relevant to the

implementation of the Project. The questionnaire contained 185 items across nine sections as follows:

- Part 1: General population characteristics (21 items)
- Part 2: Knowledge and attitudes about HIV/AIDS (32)
- Part 3: Condom use and sex behavior (21)
- Part 4: Knowledge of STI (16)
- Part 5: HIV VCT (17)
- Part 6: Receipt of information and knowledge about HIV/AIDS and condom use (18)
- Part 7: Family planning (21)
- Part 8: Access to clinical services when ill or injured (11)
- Part 9: Integration with Thai society (28)

3.1.4 Data collection, tabulation and analysis

The three survey teams consisted of a team supervisor and experienced, trained multi-lingual interviewers. Interviews were conducted during November, 2013 to January 2014. Questionnaires were field-edited for completeness and consistency. Then data were entered into computers for machine editing and tabulation. Data analysis was conducted using SPSS.

3.2 Qualitative data collection

3.2.1 Methodology and respondents groups

The qualitative data were collected by in-depth interviews (IDI) and focus group discussion (FGD) with the following:

- (1) Staff of the PR and SR agencies, including the senior managers, supervisors, and field staff including MHW and MHV;
- (2) Staff of health service outlets collaborating with the Project, including provincial, district and Tambon hospitals and community health centers;
- (3) Staff of relevant government and private agencies such as the labor office, LAO, business associations, provincial chambers of commerce, and human resources sections of employers;
- (4) Community leaders and VHV.

The evaluation team reviewed the related Project documentation from PHAMIT 1 and 2, evaluation and progress reports, proceedings of Project meetings, lessons learned documents, etc. In addition, research reports about migrants, and studies of health services and policy for MW were also reviewed.

3.2.2 Locations of qualitative data collection

Five provinces were purposively selected to include areas of Project implementation with a range of MW occupations and nationalities, as follows:

1. Provinces with MW from Myanmar: Samut Sakorn, Ranong, Tak

2. Provinces with Lao MW: Khon Kaen
3. Provinces with Cambodian MW: Rayong

The topics for the IDI and FGD include the following:

- Knowledge, attitudes and beliefs about HIV/AIDS and STI;
- Health care services;
 - Sex behavior-related and prevention;
 - Family planning;
- Access to health care:
 - Care and treatment in general;
 - HIV VCT;
 - Family planning, contraception and RH;
- Access to information about AIDS and condoms;
- Participation in Project activities;
- Satisfaction with the model of activities and services for MW (Project and non-Project);
 - Health service policy for MW in the province and country;
 - Sustainability of health services for MW.

Table 3.3: Number of Qualitative Survey Respondents by Group

Group	Number
PR and SR	19
- Manager/supervisor	
- Field coordinator/staff	
MHW	27
MHV	15
Peer educator	6
Health service outlet	20
- Provincial/district hospital	
- Private hospital/NGO clinic	
- Tambon health Promotion Hospital (THPH)/health center	
Worksite	8
Related agencies	5
- provincial labor office	
- provincial employment office	
- mass media	
- LAO	
- provincial chamber of commerce	
VHV	2
Community leaders	1
Total	103

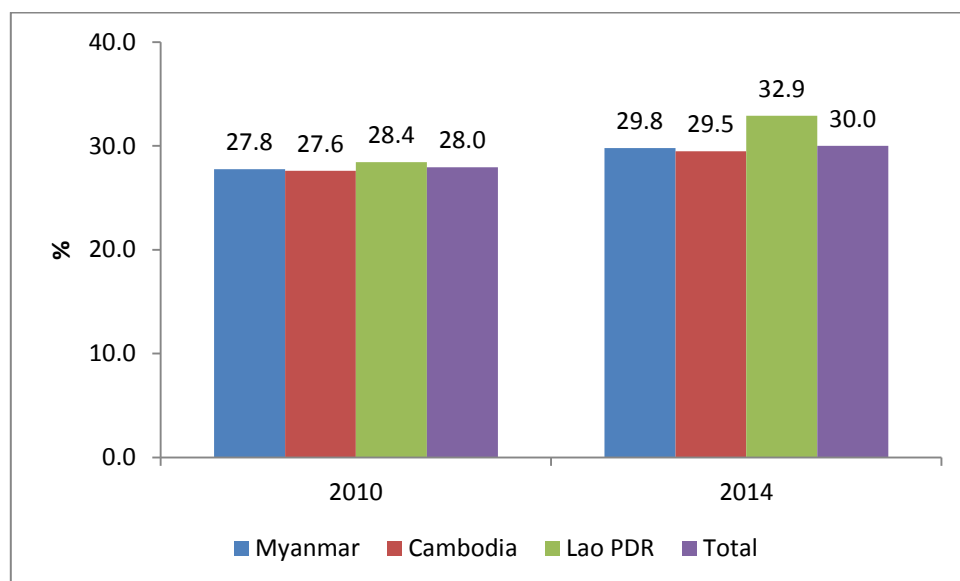
4

General Characteristics of the MW Sample

The general socio-economic and demographic characteristics of the population are important in understanding the health environment of the MW and factors which might enhance HIV prevention. This chapter presents data on the general characteristics of the sample, including age, sex, ethnicity, marital status, education, duration of residence in Thailand, occupation, duration of current employment, registration status, ID/residence documentation, income and wages, remittances to the home country, ability to communicate in Thai, domicile and integration with Thai society. The data from both the 2010 Baseline and 2014 Follow-up surveys are compared.

4.1 Age-sex distribution

Most of the MW in this sample are in the younger working-age groups; over two-thirds were under 35 years of age. The age group with the largest number of sample was 20-29, and this is logical since the jobs they come to Thailand for usually entail hard physical labor. The age distribution is similar among nationalities, with the Lao MW being slightly older, and males slightly younger than females. These patterns are also similar for both the Baseline and Follow-up surveys, though the mean age increased over rounds from 28 to 30 years (Figure 4.1).

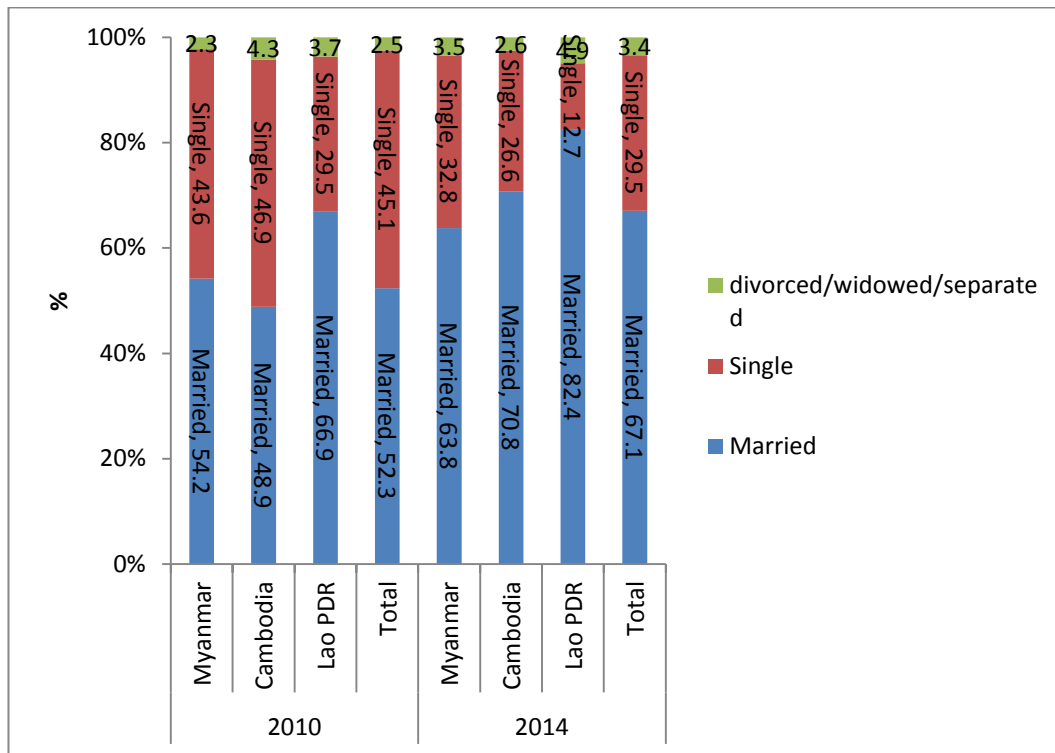
Figure 4.1 Mean Age by Nationality and Round

4.2 Ethnicity

MW from Myanmar have greater diversity of ethnic groups than the other nationalities. The Cambodian MW are predominately Khmer and the Lao MW are mainstream Lao. The Myanmar MW have Burmese, Tavoy, Mon, Rakhine and Karen ethnic groups represented in the sample, with the latter two groups increasing as a proportion when compared with 2010.

4.3 Marital status

Over half the sample was currently married, and most were living with their spouse. This proportion is an increase from the Baseline, while the proportion single declined from nearly half to one-third of MW over rounds. Many of the MW had migrated at a younger age, when they were single. But they were pressured or felt more comfortable to live in densely populated migrant communities of their own nationality and this contributed to increased cohabitation and marriage among couples (Figure 4.2). By nationality, the MW who are married or cohabiting increased over rounds for all three groups, and is higher than those who are single or divorced/separated. Lao MW, who are older on average than their Cambodian or Burmese counterparts, also have higher rates of ‘currently married’ than the other two. More female MW are in married/cohabiting relationships and this proportion increased over rounds. Males also had increased proportion of married/cohabiting over rounds but at lower levels than female MW.

Figure 4.2: Marital Status by Sex and Round

4.4 Educational attainment

Most of the sample came to Thailand in the younger part of the working age years and worked in unskilled labor jobs which did not require much education. Thus, as shown in Figure 4.3, the sample has relatively low or no educational attainment. Lao and Cambodian MW had higher and increasing proportions of those without any formal schooling compared to those from Myanmar. Female MW had higher proportions of those with no formal school than males, and this increased over rounds.

Figure 4.3: Proportion of MW with No Formal Education by Nationality and Round

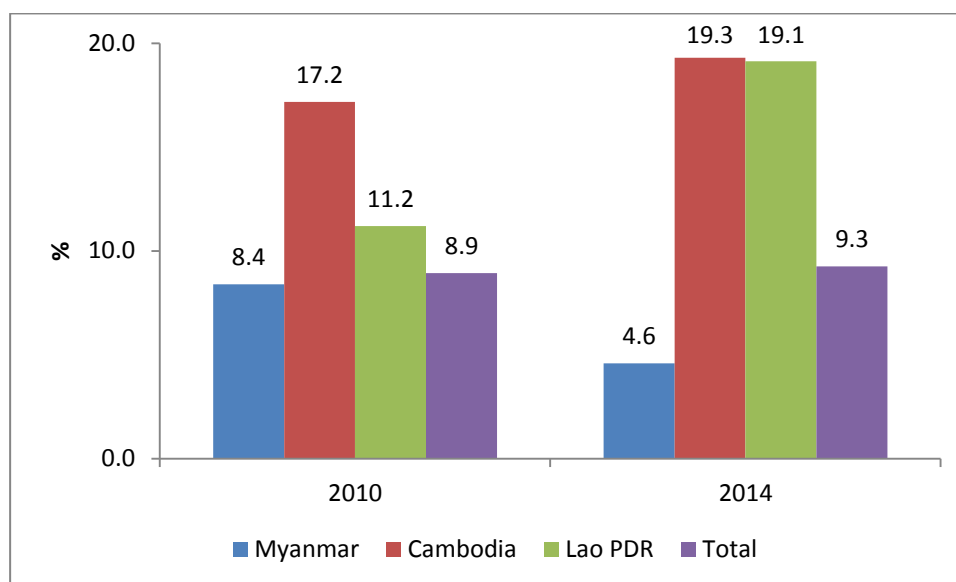
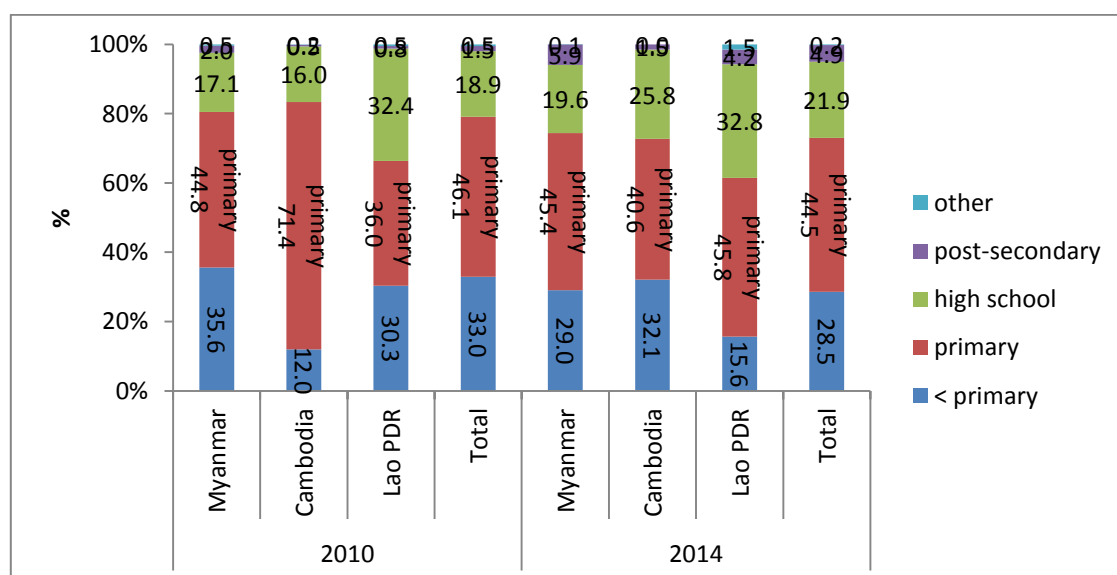


Figure 4.4 shows educational attainment by highest completed grade, nationality and survey round. Most common is primary education, and very few had post-secondary school education in both rounds for all nationalities. Males had more gains in the proportion completing high school than females.

Figure 4.4: Level of Completed Education by Nationality and Round

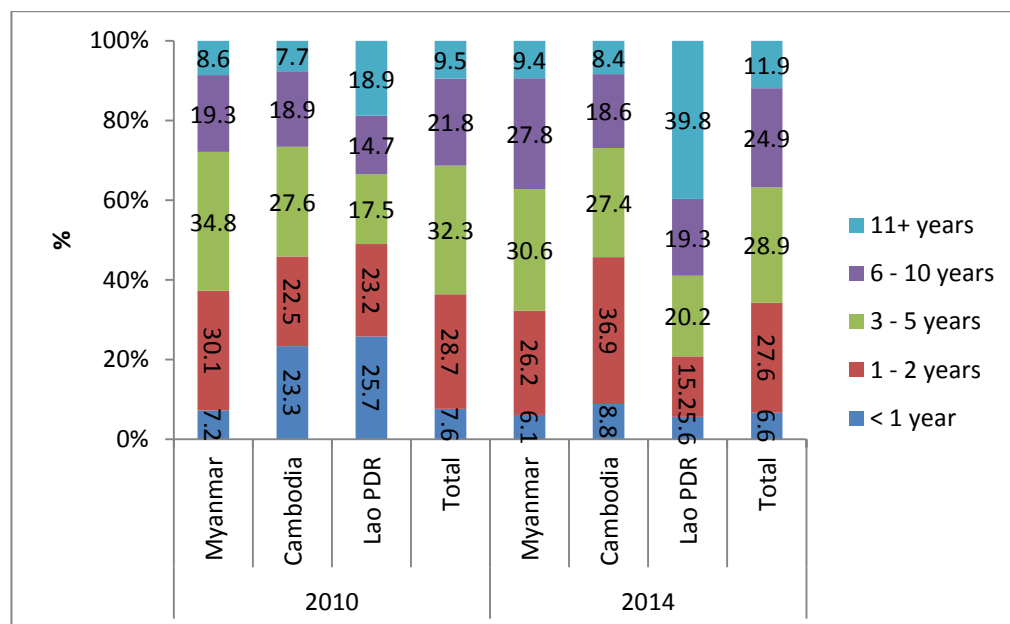


Almost all the formal education of the MW was attained in their home country, though Lao MW have some continuing education in Thailand and that trend is increasing.

4.5 Duration of residence in Thailand

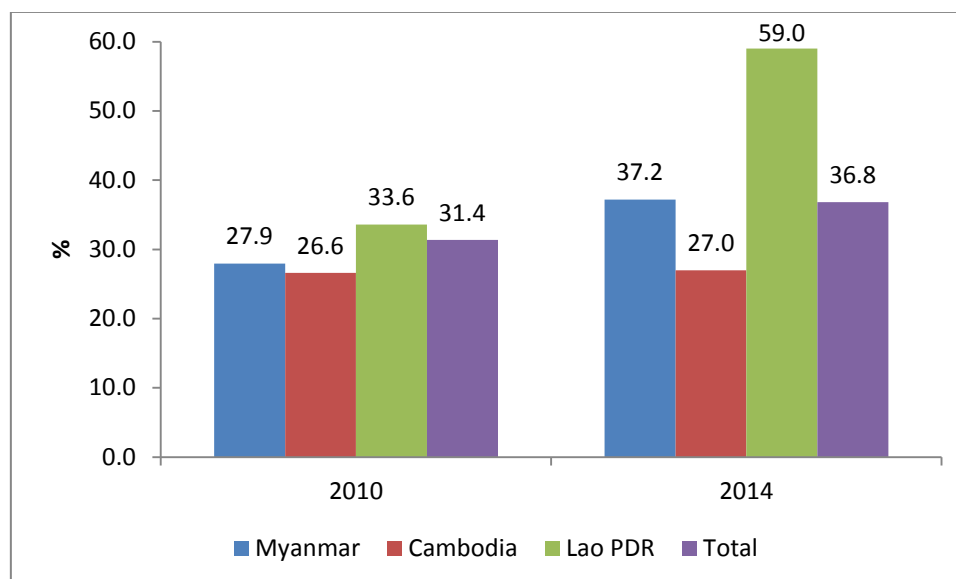
The longer a MW has lived in Thailand the better the chance that they will have adjusted to the society and economic system of the country. However, the high mobility and reverse cycles of migration of MW mean that it is difficult to measure trends over time. Other related research (Chalamwong, Y., & Prugsamatz, R. 2009; Huguet, J. W., & Punpuing, S. 2005; ILO/Japan-MOL. 2010) estimates that MW who come to Thailand intend to stay for long durations, even though they may be highly mobile and take frequent trips back home. This survey found that the sampled MW had lived in Thailand for five to six years on average. Two-thirds of the sample had been in Thailand for less than five years and this is similar across rounds. However, the proportion that had been in Thailand for six or more years increased over rounds (Figure 4.5).

Figure 4.5: Duration of Residence in Thailand by Nationality and Survey Round



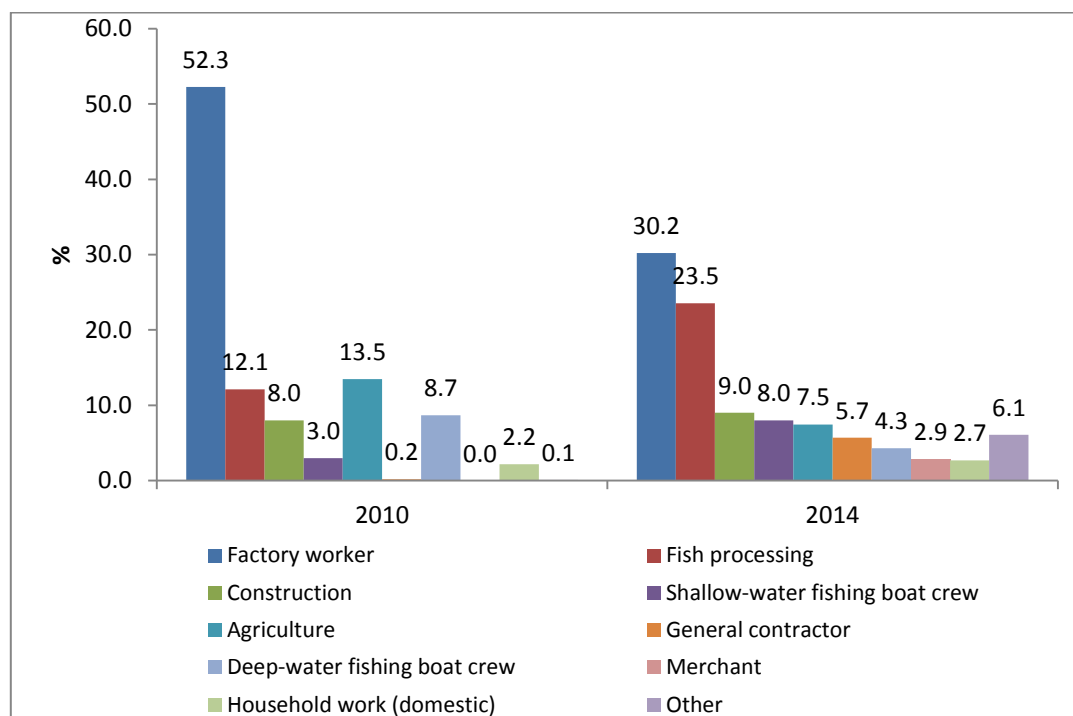
Lao MW have about twice the duration of stay in Thailand than the other two nationalities, and the average increased significantly over rounds. Thai government policy measures and MOU only address shorter durations of stay of MW (two years) and, thus, may not be consistent with the tendency of MW to stay for longer periods (Figure 4.6). Most internal migration of MW is for change of jobs and better pay.

Figure 4.6 Proportion of MW Living in Thailand for More than Five Years by Nationality and Survey Round



4.6 Occupation and duration of current employment

The type of occupation for MW from Myanmar, Cambodia and Lao PDR largely depends on the demand for low-skilled labor, and the geographical location of the industry (e.g., coastal areas have more MW working in fisheries and seafood processing, whereas rural areas have more MW working in agro-industry). The current occupation of the sample is also largely determined by the purposive selection of provinces and the inclusion stratification across the major employment areas of fisheries, factories, construction, and agro-industry. There are also MW in the sample who engage in miscellaneous wage labor and domestic helper jobs. The proportion working in fisheries in the eleven sample provinces increased over rounds (from one-fourth to one-third). (See Figure 4.7.)

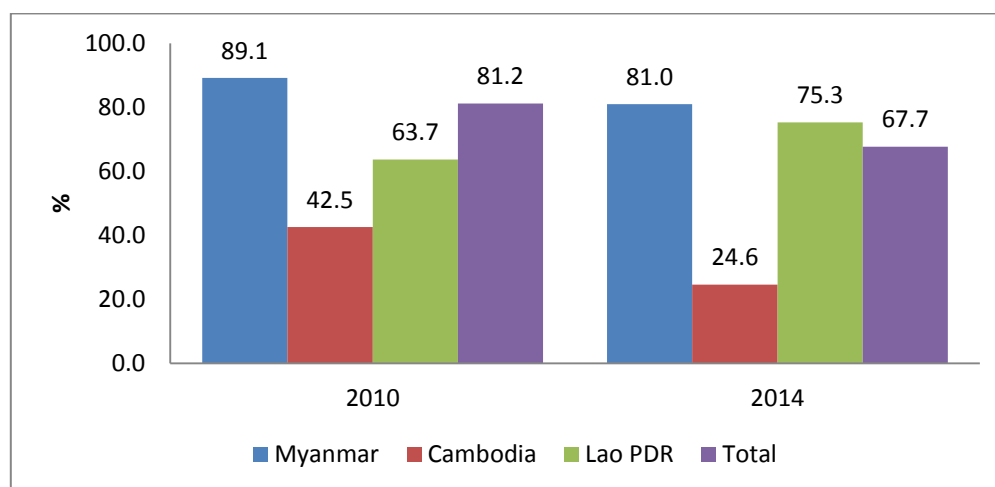
Figure 4.7: Occupation by Type and Round

Female MW are less likely to be hired in jobs requiring heavy or skilled labor, or fishing boat crew. On the other hand, factory work, especially seafood processing, is more likely to be practiced by female MW, as are domestic helper jobs. MW are clustered in certain occupations by nationality. For example, Burmese MW are more likely to be working in industrial wage labor and fisheries than the other two nationalities. By contrast, more Lao MW are found in agro-industry. Duration of employment in the current position is a measure of job satisfaction and economic stability. This survey found that the average duration in the current job was two to four years, but the average duration declined over rounds which suggests expanding economic opportunity.

4.7 Possession of a work permit and identity documentation

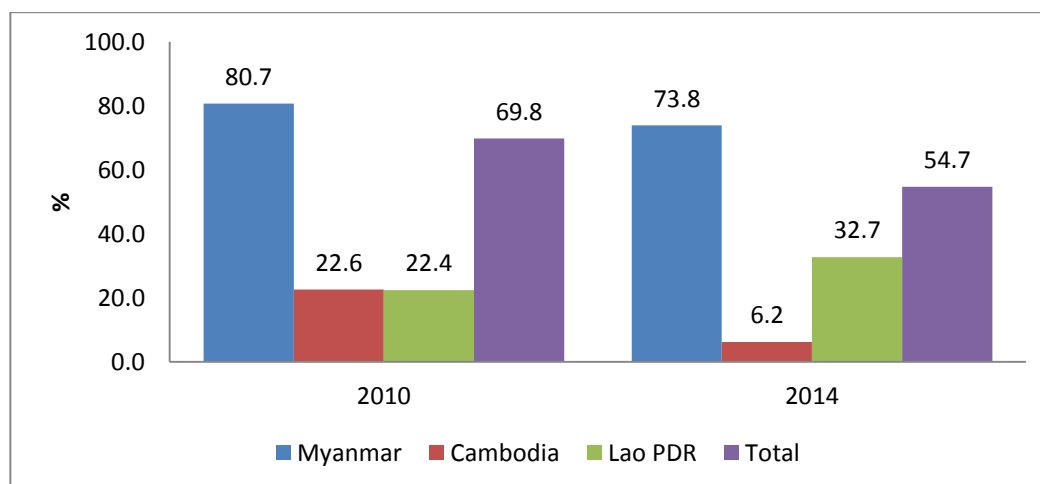
Most of the sample had ID cards and residence permits, especially the Lao and Burmese MW (Figure 4.8). Only a minority of Cambodian MW had this documentation. It is noteworthy, however, that the proportion of MW who had these documents declined over rounds (especially for Cambodians), and this could reflect the changing registration environment, or Cabinet resolutions, and variation in enforcement of Immigration violations. More male MW had residence permits than females.

Figure 4.8: Possession of ID and Residence Permits by Nationality and Survey Round



Over half the sample had work permits (Figure 4.9) but, overall, this proportion declined over rounds. Significantly more MW from Myanmar had work permits than the other two nationalities. The proportion of Cambodian MW with a work permit declined distinctly between rounds and is currently quite low, possibly due to the enforcement of nationality verification requirements. By contrast, there was an increase in the proportion of Lao MW with work permits over rounds. In addition, the MW work permits being issued have become increasingly specific about the type of employment allowed for the holder. The proportion of MW in 2014 who had work permits for miscellaneous jobs or unspecified jobs decreased significantly.

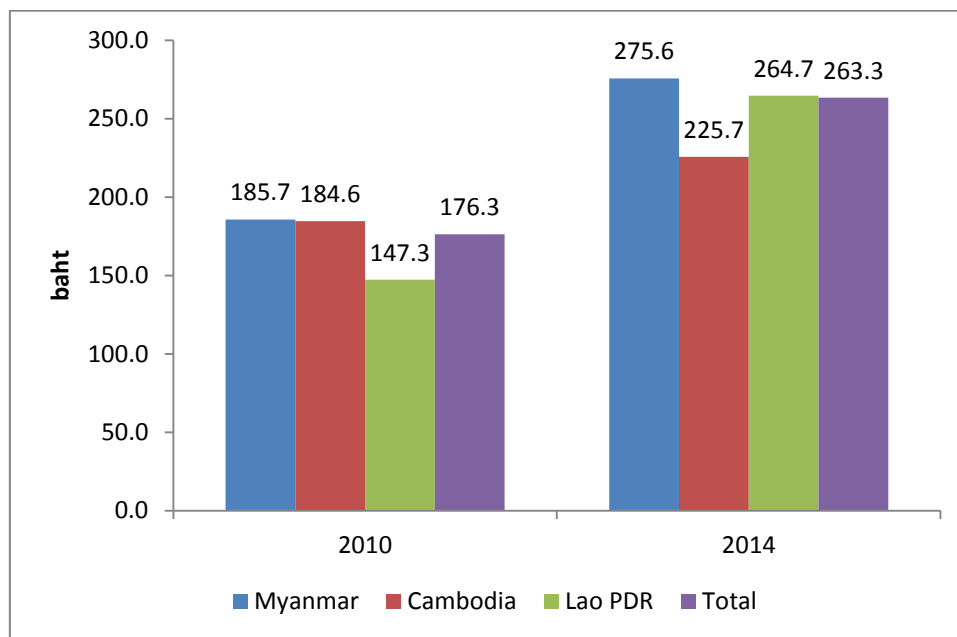
Figure 4.9 Possession of a Work Permit by Nationality and Survey Round



4.8 Income and wages

Between 2010 and 2014 there were significant increases in the wages/income of MW in the samples of these two surveys. Part of this is due to the national increase in the minimum wage for all workers in Thailand, regardless of nationality. Even so, many MW are still not paid the minimum wage and there are distinct differences in income by nationality, as MW from Myanmar had higher average daily wages than the other two nationalities in both rounds (Figure 4.10). Also, male MW had higher average wages than females, which was as high as 50 baht-per-day different for Burmese and Cambodian MW.

Figure 4.10 Average Daily Wage by Nationality and Survey Round



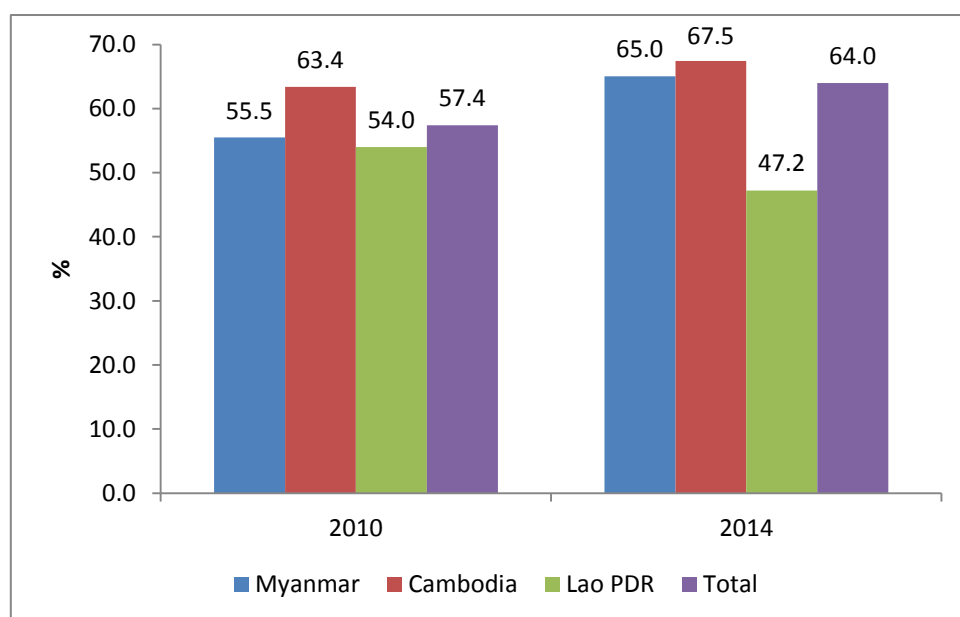
Although MW were not sure if their wages in Thailand were higher or lower than they could earn for the same job in their home country, they clearly came to Thailand for work because of the greater availability of jobs and not necessarily the higher income.

4.9 Remitting funds to the home country

Many of the MW left their home communities and loved ones in order to provide a better life for themselves and their relatives who stayed behind. This survey found that over half the sample of MW sent funds back to their home country, and this did not change much over rounds (Figure 4.11). The MW can remit

funds via the employment agency that recruited them, or by relatives who travel back and forth between countries, through bank transfers or other means. It is noteworthy that, even though there are banking relationships between the three countries and Thailand, the MW prefer to use non-formal mechanisms for remitting funds, out of familiarity or trust.

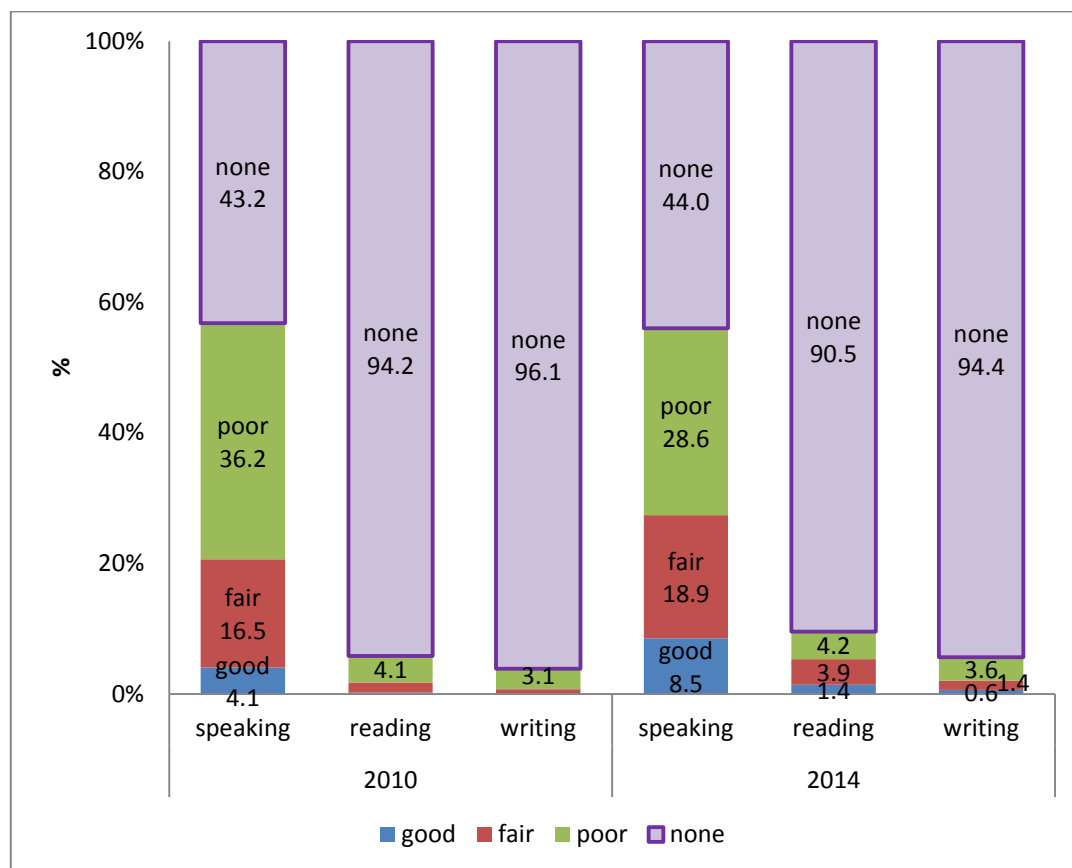
Figure 4.11 Proportion Remitting Funds to the Home Country by Nationality and Survey Round



4.10 Ability to communicate in Thai

Ability to communicate in Thai is crucial in expanding the employment, income and advancement opportunities for the MW population. Language ability is also critical for staying informed and learning about services and benefits that the MW are eligible for, and how to access these when needed. This survey found that only about half of the sample could communicate verbally in Thai (Figure 4.12), and less than one-tenth could read or write Thai.

Figure 4.12 Proportion Who Can Communicate in Thai by Mode and Round



Given the similarity of Thai and Lao languages (both spoken and written) it is no surprise that four-fifths of the Lao MW could communicate effectively in Thai, and two-thirds could read Thai, while one-third could write Thai. Significantly lower proportions of Burmese and Cambodian MW could functionally communicate in Thai.

4.11 Domicile

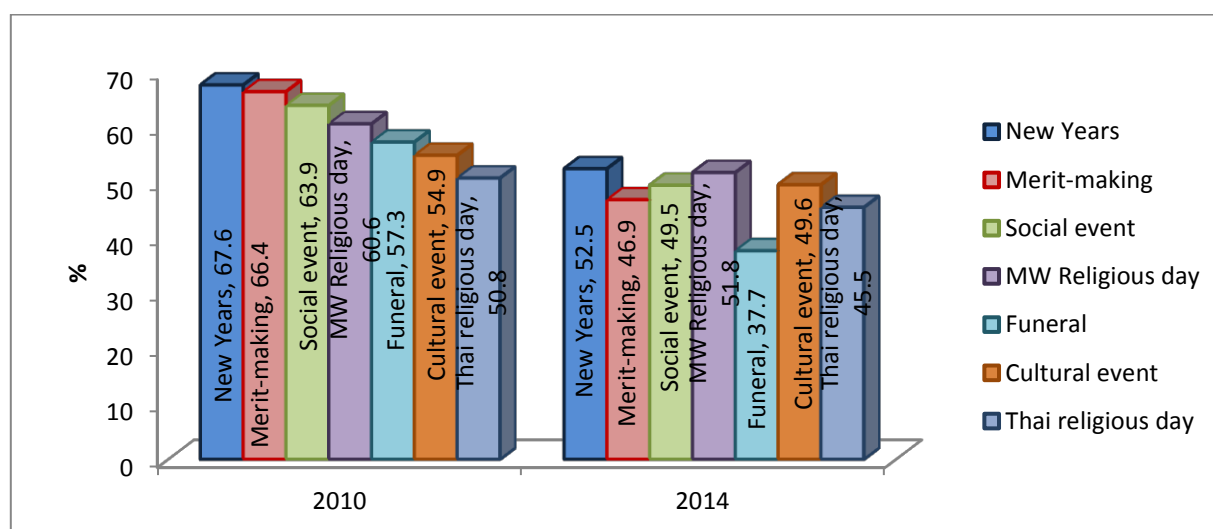
Most of the MW lived in dwellings with family members (e.g., spouse, and or blood relative) or friends and co-workers. The proportion living with a spouse increased from half to about three-fourths of MW over rounds. A significant proportion of Burmese MW lived in employer-provided housing but this declined over rounds. By contrast, a large proportion of Cambodian MW lived in worksite housing or on the boats they crewed, and this increased over rounds. Few MW lived alone. More Lao lived with family members than the other

nationalities, and this may reflect the easier ability to integrate with Thai culture and society.

4.12 Integration into Thai society

The degree to which the MW can assimilate with Thai culture and interact with Thais is an important determinant of their ability to access information and services, and experience better quality of life. These contacts may also lead to better employment options, rather than only socializing in segregated migrant communities with others of the same nationality. The more they become involved in the larger community, the more accepted they will be and the faster they will gain fluency in the Thai language.

Figure 4.13: Proportion who Participate in Community Activities by Type and Round

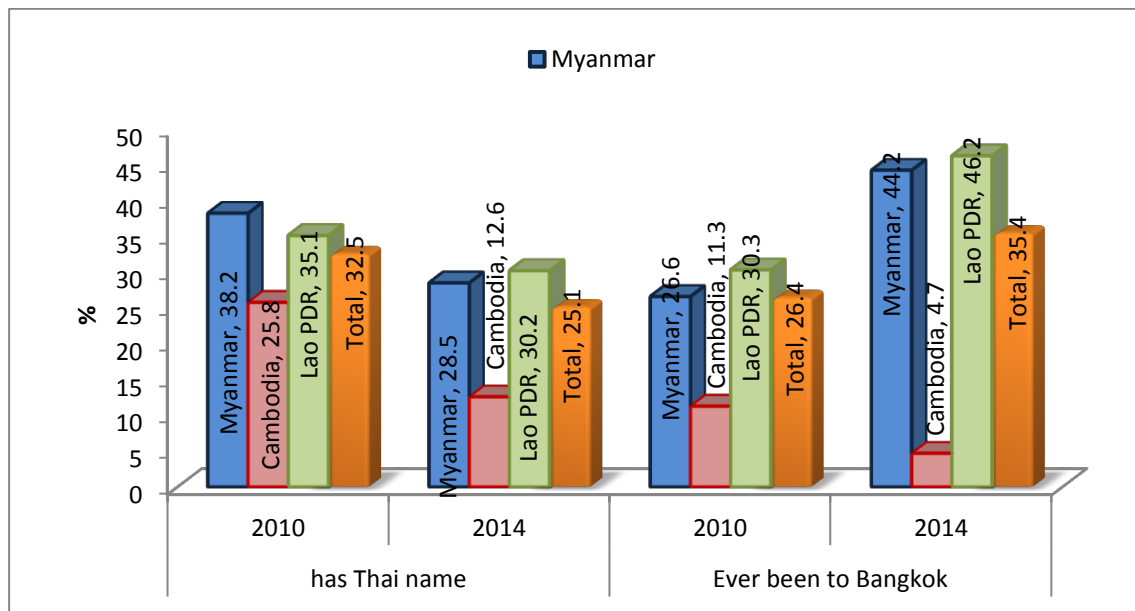


MW commonly participate in the New Year's festivals of the community, but this declined in popularity over rounds. Other popular festivals include important Buddhist holidays (since all three MW countries are predominately Buddhist societies) and merit-making events (Figure 4.13). But participation in these events also declined over rounds which may reflect the increasing multiculturalism of these populations and the use of electronic and social media as pastimes. Thus, ironically, while it is easier to travel and communicate among populations, modern technology may result in increased segmentation and segregation of minorities. The Burmese MW are more likely to participate in community events with their fellow Burmese, whereas the Cambodian and Lao

integrate more with local Thais during festivals and community activities (Table 4.2).

Only a minority of the MW have adopted a Thai name (Figure 4.14) and this is one indicator of the extent of integration (or lack thereof) of the MW into mainstream Thai society. The proportion of MW with a Thai name declined over rounds from one-third to one-fourth, and this trend occurred for all three nationalities.

Figure 4.14: Proportion Who Have Thai Names and Who Have Ever Travelled to Bangkok by Sex and Nationality



Less than half of the MW in the 2014 survey had ever visited Bangkok, but the proportion who had increased significantly for Lao and Burmese MW over rounds, while decreasing for Cambodian MW.

Regardless of the degree of acculturation or assimilation of the MW into Thai society, there is no doubt that the MW are helping the Thai economy to expand, and expand rapidly as the pace of industrial development increases. They are not replacing Thais in the labor force; instead they are taking the jobs that Thais now shun (i.e., the “dirty, difficult and dangerous” jobs). This is having an impact on the economies and societies of both the sending countries and Thailand. However, the MW income is low and many of the MW are illegal and at constant risk of exploitation or deportation. *Still, the need for work is so great as to continue to encourage the lower-income working age population to take*

the risk. Thus, the MW have made the internal cost-benefit analysis of staying in the home community or migrating across borders to work in a foreign land, and have concluded that, while some aspects of their daily life and welfare may decline by comparison with home, the opportunity for gaining income and opportunity in Thailand outweigh those drawbacks.

5

Knowledge, Understanding and Attitudes toward HIV/AIDS

Correct knowledge, understanding and attitudes toward HIV infection are a foundation for behavior change to prevent infection and to facilitate a sustainable response to the AIDS epidemic in general. The MW in Thailand face considerable obstacles that Thais do not in accessing public and private services. There are barriers regarding Immigration and employment, communication, and culture which impede the delivery and access to services. This chapter presents results from the Baseline (2010) and Follow-up (2014) surveys regarding changes in knowledge, understanding and attitudes toward HIV/AIDS among the sample of MW.

5.1 Awareness of AIDS

A high percentage (91%) of MW already knew about HIV/AIDS in 2010 and the proportion increased to 97% by 2014. The proportion who knew a PLHIV increased from 30% to 45% over rounds. The proportion who knew someone who had died of AIDS increased from 26% to 39% over rounds. Cambodian and Lao MW had generally higher awareness of HIV than their Burmese counterparts in both rounds.

5.2 Knowledge of HIV prevention

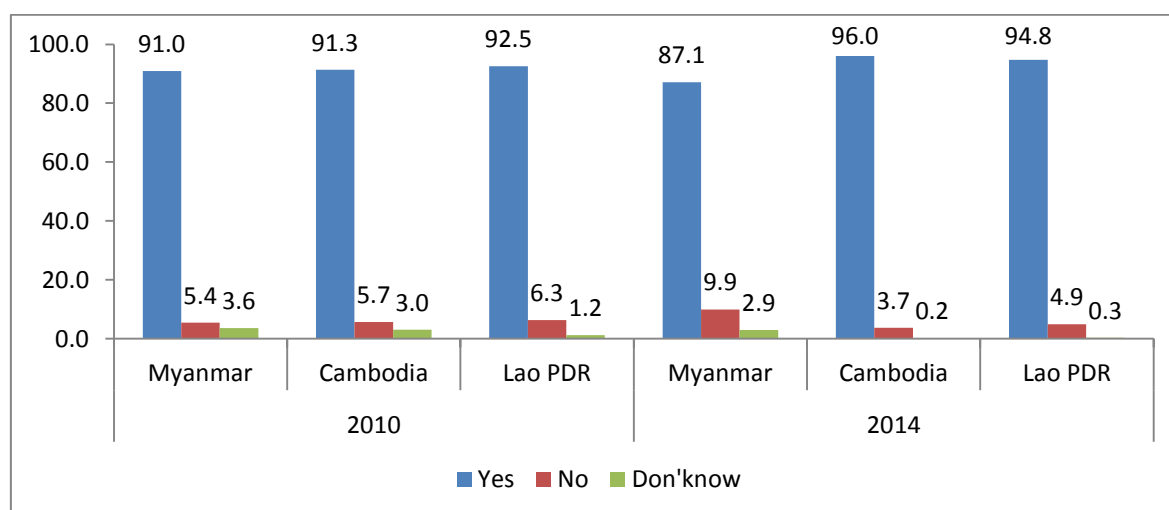
After probing for more in-depth knowledge about HIV/AIDS, it is clear that the MW are well-informed. They understand that HIV is preventable and that condoms are effective prevention, with an increase from 87% to 92% over rounds who agreed with this. Knowledge was similar among the three nationalities. Almost all of the Burmese and Lao MW also knew that being in a mutually faithful sexual

relationship greatly reduces risk for HIV (ranging from 90 to 99% respectively), but only four-fifths of the Cambodian MW were aware of this. Lower percentages knew that reducing the number of sex partners reduces risk of HIV (67%, 76% and 96% of Cambodian, Burmese and Lao MW respectively). The pattern and level who knew that abstaining from sex reduces HIV risk was similar and generally constant over rounds. Overall, it is observed that the Lao MW reflected a more conservative culture when it comes to sex, and that could explain their higher level of correct response on sex and HIV risk.

5.3 Knowledge of the routes of HIV transmission

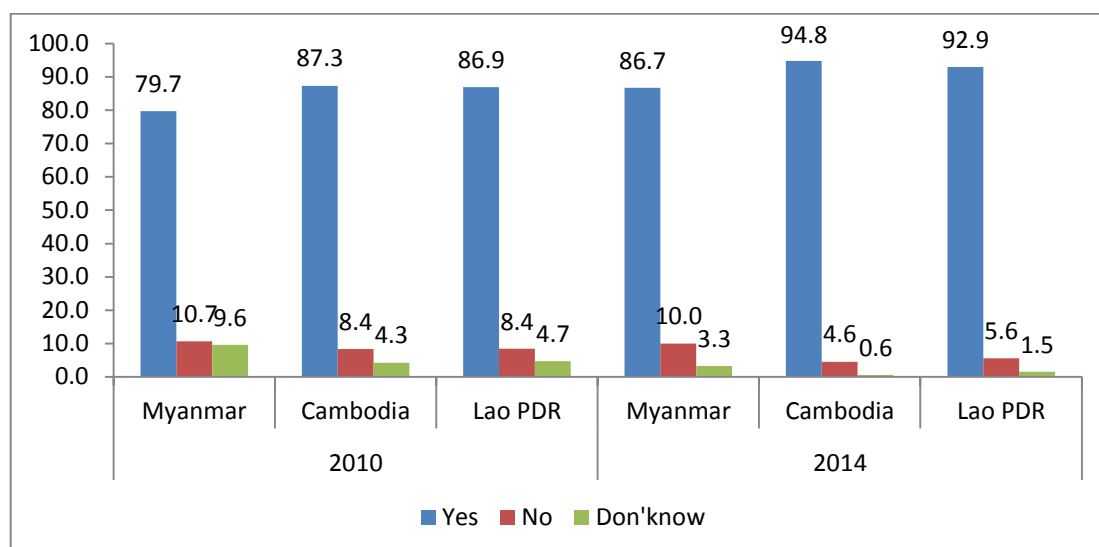
In the 2014 survey, from 87% to 96% knew that HIV could be transmitted by sharing needles for IV injection, and this was an increase over 2010 (Figure 5.1).

Figure 5.1: Percent Knowing that Sharing Needles Can Transmit HIV by Nationality and Round



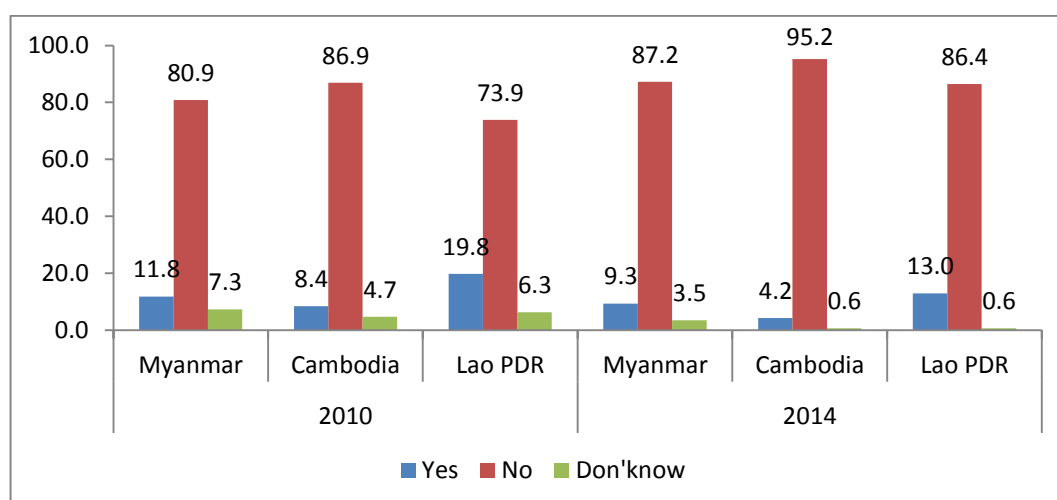
Most of the MW in each nationality group knew that HIV can be transmitted by contamination with infected blood, and this increased over rounds from 78% to 89% (Figure 5.2).

Figure 5.2: Percent Knowing that HIV Can Be Spread by Blood by Nationality and Round



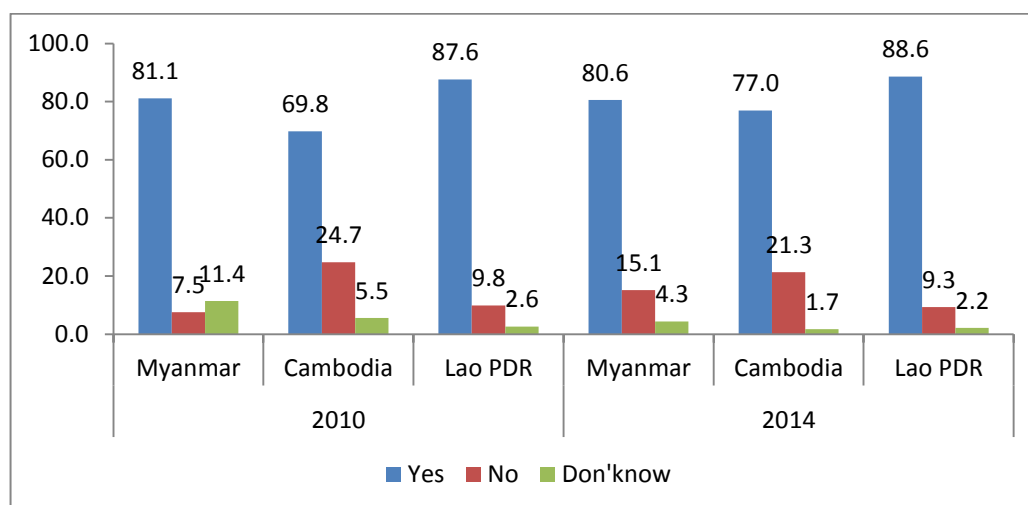
Similarly high proportions of all MW knew that HIV cannot be transmitted by sharing a meal with PLHIV, increasing from 78% to 89% across rounds (Figure 5.3).

Figure 5.3: Percent Knowing that HIV Cannot Be Transmitted by Sharing Meals with a PLHIV by Nationality and Round



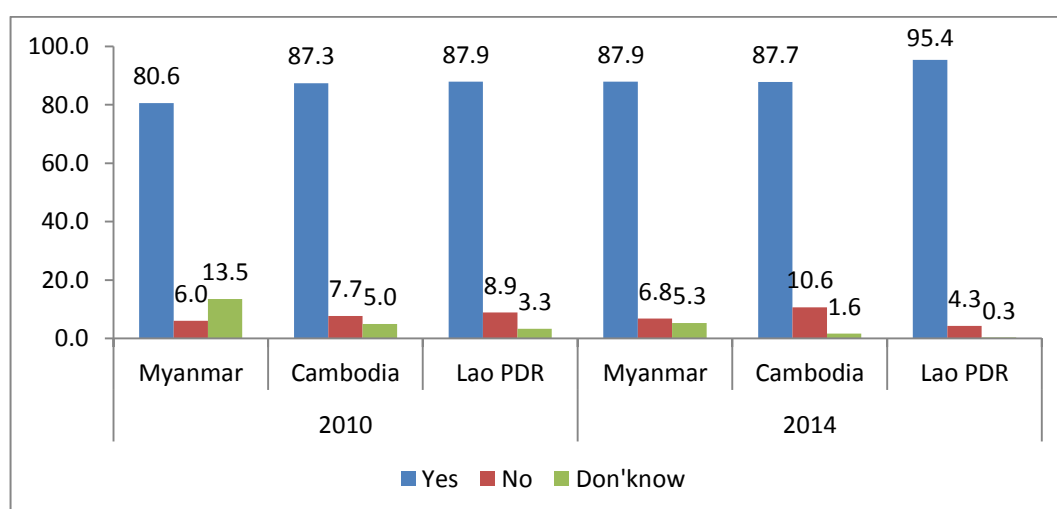
Fully 81% of MW from Myanmar and 89% of Lao MW knew that HIV can be transmitted from an infected pregnant woman to her fetus, while 70% of Cambodian MW knew this (Figure 5.4).

Figure 5.4: Percent Knowing that HIV Can be Transmitted by an Infected Pregnant Woman to Her Fetus by Nationality and Round



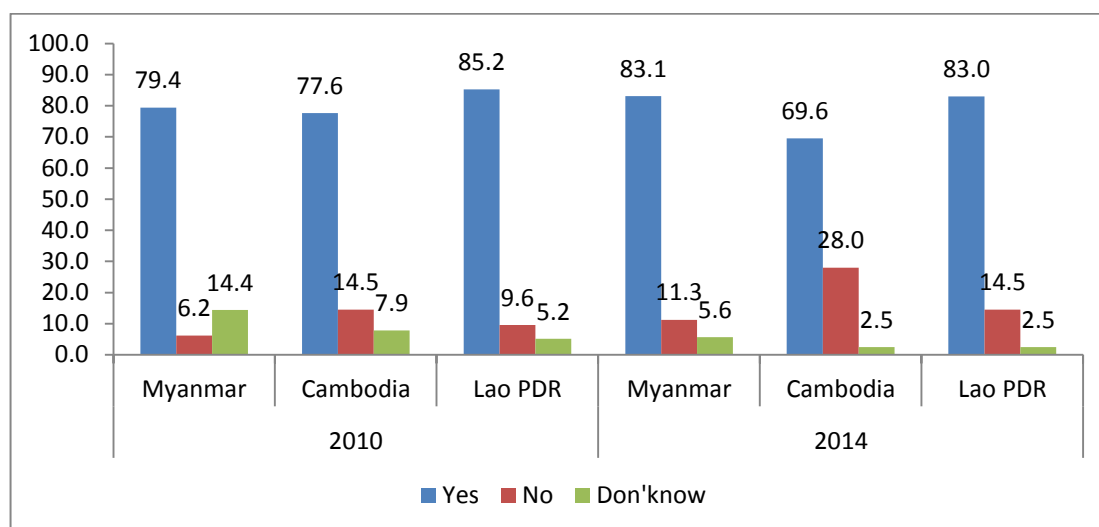
The proportion knowing that an infected mother can transmit HIV to her infant via breastfeeding increased from 88% to 95% over rounds for Lao MW, and from 81% to 88% for MW from Myanmar (Figure 5.5).

Figure 5.5: Percent Knowing that an Infected Mother Can Transmit HIV to Her Infant by Breastfeeding by Nationality and Round



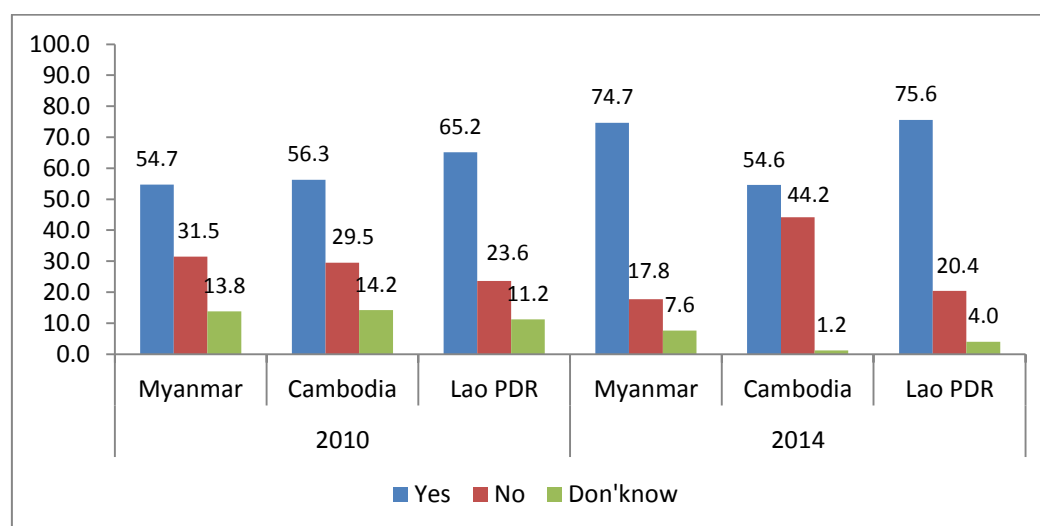
However, there was less knowledge that HIV can be transmitted during child delivery, and correct knowledge declined over rounds for Cambodian and Lao MW (Figure 5.6).

Figure 5.6: Percent Knowing that HIV Can Be Transmitted During Delivery by Nationality and Round



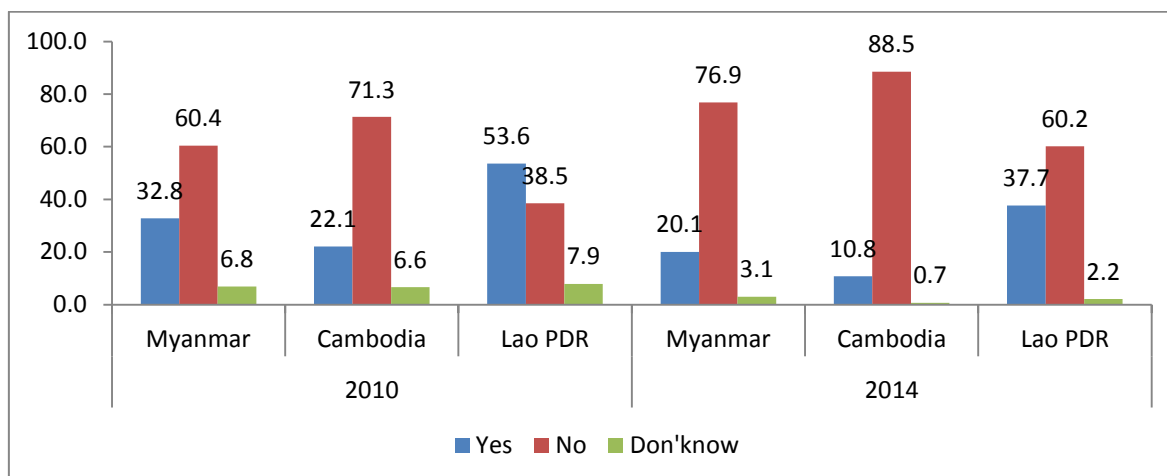
About half the MW in 2010 knew that someone who looks healthy can still be HIV+, but the proportion increased to 70% by 2014. Increases in knowledge were more among the Burmese and Lao MW, while Cambodian MW knowledge was unchanged over rounds (Figure 5.7).

Figure 5.7: Percent Knowing that Person Who Looks Healthy Can Be HIV+ by Nationality and Round



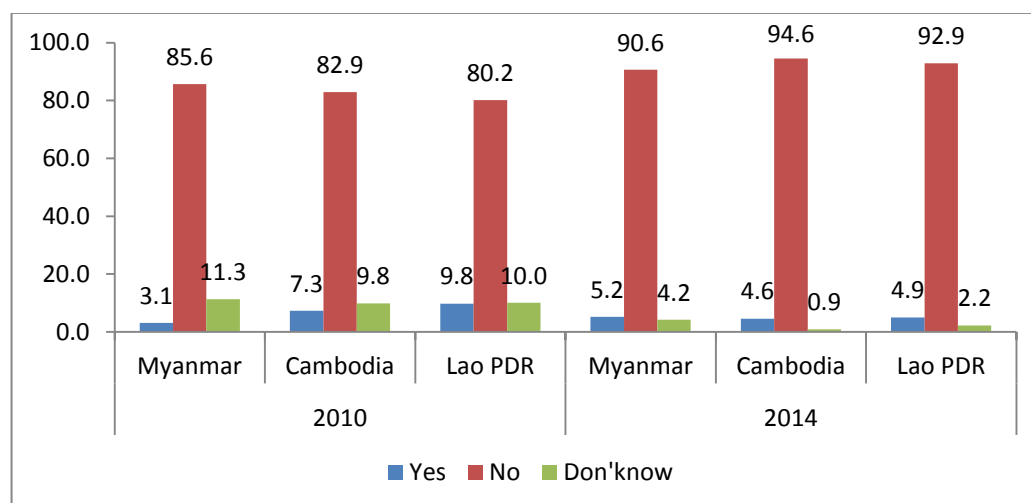
The area of least correct knowledge concerns whether HIV can be transmitted by mosquito bite, as about 38% of Lao MW believed this compared to 20% and 11% of MW from Myanmar and Cambodia (Figure 5.8).

Figure 5.8: Percent Who Believe that HIV Can Be Transmitted by Mosquito Bite by Nationality and Round



Over 90% of all groups of MW did not believe that HIV could be caused by supernatural means (Figure 5.9).

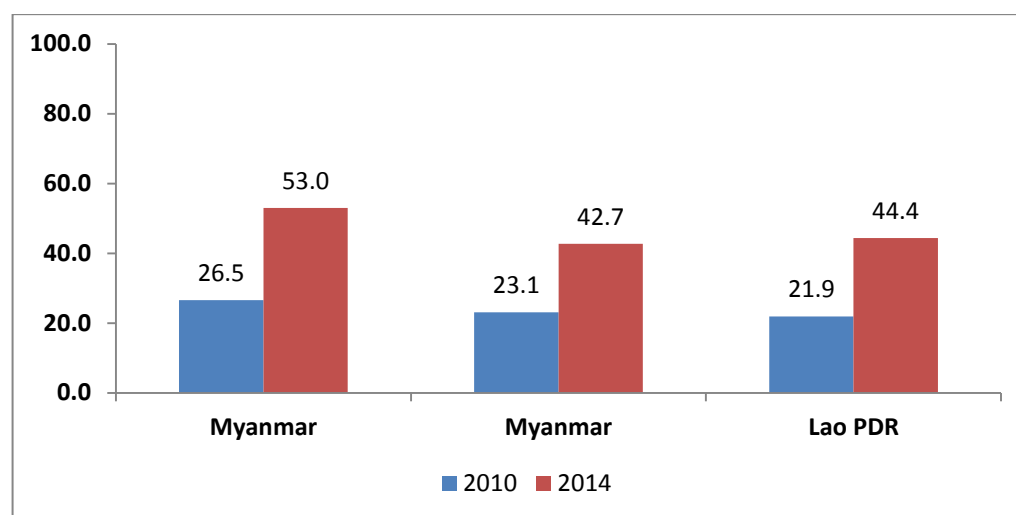
Figure 5.9: Percent Who Believe that HIV Can Be Transmitted by Supernatural Means by Nationality and Round



In sum, for the preceding HIV/AIDS knowledge items, it can be concluded that the MW showed increased knowledge between the Baseline and Follow-up Survey rounds, but there is still room for improvement in accordance with UNGASS standards. Figure 5.10 shows the proportion of MW who correctly answered the following five items: (1) HIV cannot be transmitted by sharing a meal with a PLHIV; (2) HIV cannot be transmitted by mosquitos; (3) HIV can be prevented through mutually-faithful monogamy; (4) A person who looks healthy could be HIV+; and (5) Condoms can prevent HIV. Even though the proportion of MW who correctly answered all five items is not that high, correct knowledge doubled over

rounds from one-fourth in 2010 to about half of the weighted sample in 2014. Knowledge was highest and increased the most for the MW from Myanmar. The levels and patterns were the same for male and female MW.

Figure 5.10 Percent Who Correctly Answered the 5 UNGASS AIDS Knowledge Items by Round



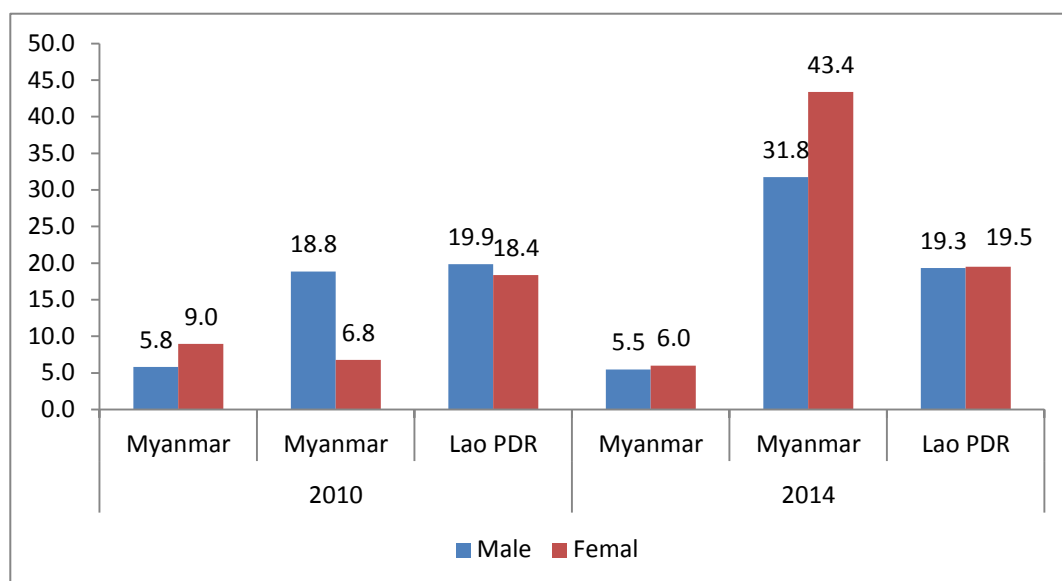
5.4 Knowledge and misunderstanding about anti-retroviral therapy (ART)

As ART continues to evolve from the initial mono-therapy of AZT to the more complex, multi-drug combination pills, it is possible that there is some level of ignorance in the general and migrant populations about the latest ARV drugs, and belief in myths surrounding their use and effectiveness. Correct knowledge of PMTCT by using ART increased among MW from 36% to 57% across rounds. However there is confusion about whether ART is a cure or just a treatment, and this may reflect the distinction between having HIV without symptoms and having symptomatic AIDS.

5.5 Assessment of risk for contracting HIV

The evaluation surveys asked the respondents to assess their own risk for HIV. Self-risk perception increased over rounds for female Cambodian MW (from 7% to 43%) and male Cambodian MW (from 19% to 32%). Self-risk perception for Lao MW remained constant at around 20% (Figure 5.11).

Figure 5.11: Percent Who Perceive Themselves at Risk for HIV by Nationality and Round



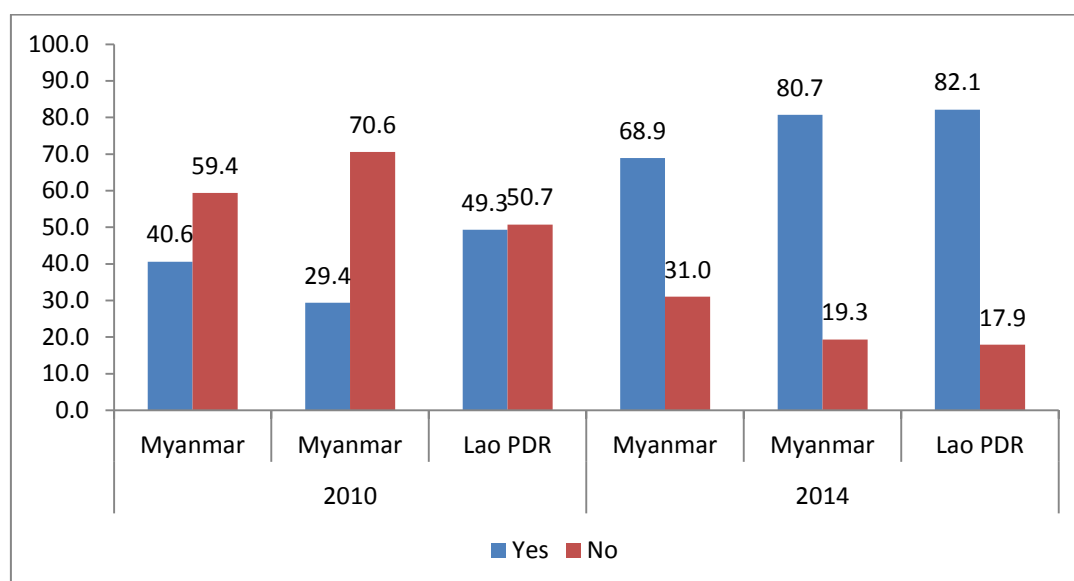
Perception of risk can either be accurate or inaccurate. The reasons given for perceived risk did not change over rounds, and male MW mostly cited having sex with a FSW or not using condoms for every sex as the reason for their concern. Having sex without a condom was the most common reason for perceived risk for female MW. The level of perceived self-risk declined over rounds for these two risk behaviors, suggesting that risk behavior decreased or risk perception became less exaggerated. By contrast, perceived risk of HIV from sharing meals with a PLHIV and having a blood transfusion actually increased over rounds, especially for the MW from Myanmar and Cambodia.

Even though self-risk perception was rather low in 2010 (8%), as many as 43% of female Cambodian MW perceived some risk for HIV in 2014. As noted, this could either be exaggerated fears and not an actual reflection of increased risk behavior of themselves or their partners.

5.6 Knowledge of an HIV VCT site and process of service

Skill in HIV prevention includes knowing where and how to get tested for HIV if one actually has some risk for infection. In the Baseline survey fewer MW knew of a VCT outlet than those who did not or were unsure (38% and 62% respectively). Lowest knowledge of VCT was among the Cambodian MW. However, by 2014, the trend had reversed and 73% of MW knew of a VCT outlet in their neighborhood compared to 27% who did not. Such a dramatic change in a short period of time is probably attributable to the Project, especially for the Cambodian MW (Figure 5.12).

Figure 5.12 Percent Who Know/Don't Know a Nearby VCT Outlet by Nationality and Round



MW were asked whether they thought their confidentiality would be protected if they went for testing at a VCT clinic. In both rounds, about two-fifths of respondents were confident in the confidentiality of the clinic, but there was a slight increase in those who said they did not think the VCT results would be kept private. By nationality, Cambodians had more confidence in the confidentiality of the HIV testing results than the Burmese and Lao MW (70%, 24% and 56% respectively). Thus, in order to improve use of VCT by those at risk of HIV, there is a strong and urgent need to increase confidence in confidentiality of HIV test results for all groups of MW, but especially the MW from Myanmar. Otherwise, proximity of VCT services will not necessarily improve uptake.

5.7 Opinions about gender roles related to sex

Gender parity is an important factor in HIV prevention since safe sex requires cooperation of both partners and mutual respect for each other's health and safety. However, cultural norms can overrule individual preferences and attitudes when it comes to gender roles and sex. Thus, change needs to happen at both the societal and individual level to create an enabling environment for safe sex. The evaluation surveys asked respondents eight questions about gender roles and sex. More male MW than females believed that the man should be responsible for condom use, not the female. In 2010, both male and female Lao MW felt that a woman who carried condoms was immoral (57% and 59% respectively). The proportions of Lao MW feeling this way declined by 2014 to 38% and 50% respectively. MW from Myanmar and Cambodia were less judgmental of women concerning this item. By

contrast, more Lao MW felt that it was acceptable for the woman to propose condom use to her male partner, and this is somewhat inconsistent with the above negative attitude toward women who carry condoms. *It is possible that the association of condoms with commercial sex is still deeply ingrained of the populations from these three countries, and it will take time to change the image of the condom from FSW-STI-prevention to a sexual health aid for everyone in society who is sexually active.* About one-third to two-fifths of Lao and Burmese MW did not approve of the idea of the woman proposing condom use to her male partner, and this opinion remained roughly constant over rounds.

MW were also asked if it was acceptable for in-school teen youth to have love relationships. Cambodian MW were the most conservative about this as 75% and 85% in 2010 and 2014 did not think that these youth should be involved in boyfriend/girlfriend relationships while in school. The opposite opinion was held by the MW from Myanmar among whom 64% and 80% (across rounds) felt it was OK for school youth to have intimate relationships.

The extent to which a culture values the virginity of pre-marital female youth can be a barrier to sex education and prevention for teens. Most of the MW in this evaluation did not feel that a young woman's worth is determined by her virginity status (78% and 82% across rounds for Lao MW; 60% and 75% for Cambodian MW; and 56% and 96% for Burmese MW). MW were also asked what they thought about same-sex relationships. The Lao MW were most tolerant of homosexuality as 65% and 78% (by round) felt that same-sex sexual attraction was normal. The opposite was true for Burmese and Cambodian MW among whom 67% and 71% and 61% and 70% disapproved of same-sex relationships by round, respectively.

Even though the MW from Myanmar seem more conservative about sex issues, fully 59% in 2010 and 64% in 2014 agreed with the idea of having discussions about sex in the school classroom setting. By contrast, 74% in 2010 and 81% in 2014 of Cambodian MW felt there should be no classroom discussion of sex. The corresponding disapproval rate for Lao MW was 56% and 65% by round.

5.8 Knowledge about and access to condoms

Nearly all the MW in the sample knew what condoms are, though 15% of female Burmese MW in 2010 had never seen a condom, but this declined to 7% by 2014. Most knew that condoms are effective in preventing HIV, STI and pregnancy. Cambodian MW had the highest knowledge of the dual protection property of condoms. MW were aware of a variety of condom outlets. About half of Burmese MW cited drug stores as a source of condoms in 2010, followed by 44% of

Cambodians. Government hospitals were the most cited source of condoms for Lao MW, possibly because they faced fewer language barriers in going to government outlets than the MW from Myanmar and Cambodia. But the proportion of Lao who cited convenience stores as a source for condoms increased from 17% in 2010 to 40% in 2014, compared to only 17% of Cambodian MW in both rounds. Fully 39% of Cambodians cited NGO clinics or outlets as a source of condoms.

One-third of Cambodian MW knew that they can get condom resupply from a Project MHV, compared to only 12% of MW from Myanmar. Also, 19% of Cambodian and 12% of Burmese MW cited condom resupply dispensers as a source of condoms, while almost no Lao MW cited this source. Among NGOs, RTF was cited most by MW from Myanmar and Cambodia as a source of condoms, followed by FAR, WVFT and the AIDS Network Development Foundation.

Overall, the MW felt that condoms were universally available and affordable or free, though 16% of MW from Myanmar felt that access to condoms was not that convenient in 2014. However, variations in access could also be related to the types of occupations of the MW. Still, the Project should have filled these gaps in access during the five years of implementation.

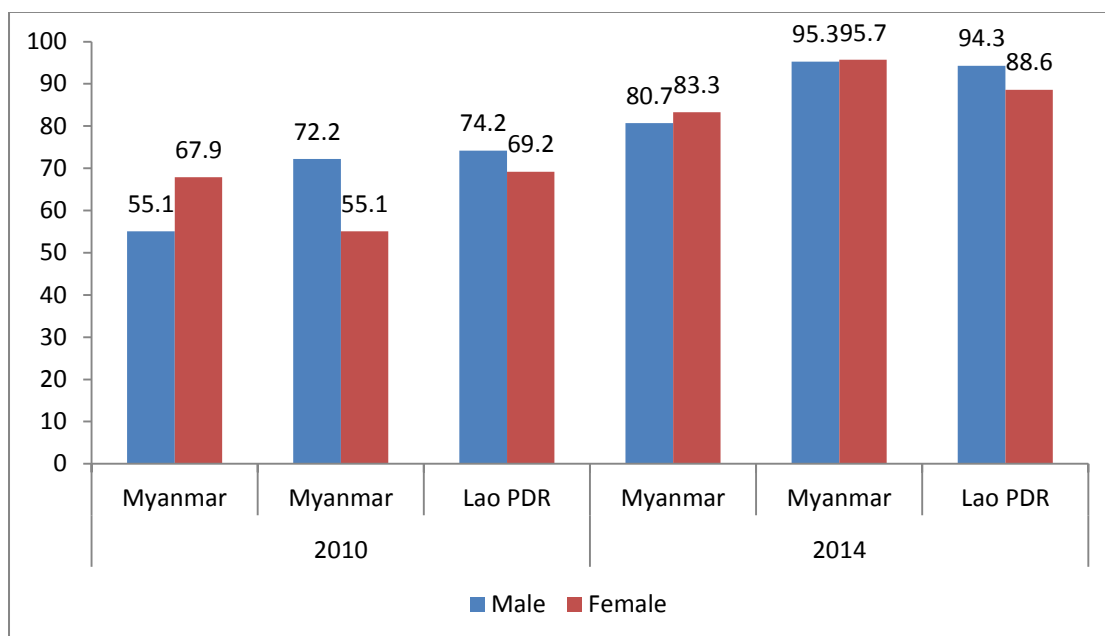
6

Knowledge, Understanding and Prevalence of STI

The massive response to the Thai HIV epidemic by domestic and international agencies overshadowed the role that STI play in creating an environment for HIV spread and increasing infectiousness and susceptibility to HIV if an STI is present. Thus, while knowledge of HIV/AIDS may be widespread among the MW sample, it is also important to assess knowledge of STI since the method of prevention of sexual transmission is the same. This information can help inform policies and plans to improve the RH of MW in Thailand as that promotes the health not only of the migrant community but also the Thais that interact with the migrants. Table 6.1 in Appendix A summarizes the findings from both survey rounds.

6.1 Knowledge and understanding of STI

Most (86%) of MW in 2014 had heard of STI, and this represented an increase from 62% in the Baseline. MW from Myanmar had greater knowledge gain, but had a lower base of knowledge of STI than their Lao and Cambodian counterparts (Figure 6.1).

Figure 6.1: Percent Knowing of STI by Nationality and Round

Another indicator of Project success is the percent knowing that having an STI increases risk of transmitting/contracting HIV. This evaluation found that knowledge of this indicator was about 90% in both rounds for each group of MW. Generally, female MW were more aware of the symptoms of common STI than males, and there were slight gains over rounds for the entire sample. Overall, the MW were generally well-informed that symptoms of STI include genital discharge, painful urination, and genital lesions, rash or swelling.

6.2 Self-reported symptoms of STI

MW were asked whether they had symptoms that are suggestive of an STI in the 12 months prior to the interview. Indeed, the proportion reporting genital discharge or foul odor increased from about 1% to 8% over rounds. Male Cambodian MW reported the highest prevalence of these two STI symptoms in 2010 (4%) while male MW from Myanmar had the highest prevalence of symptoms in 2014 (15%). Female MW from Myanmar also had the highest prevalence of these two STI symptoms among the three nationalities. *More in-depth research is needed to determine if these self-reported symptoms reflect actual incidence and prevalence of STI or simply non-venereal fungal infections.* (Only trace levels of MW reported genital lesions or pain in both rounds.)

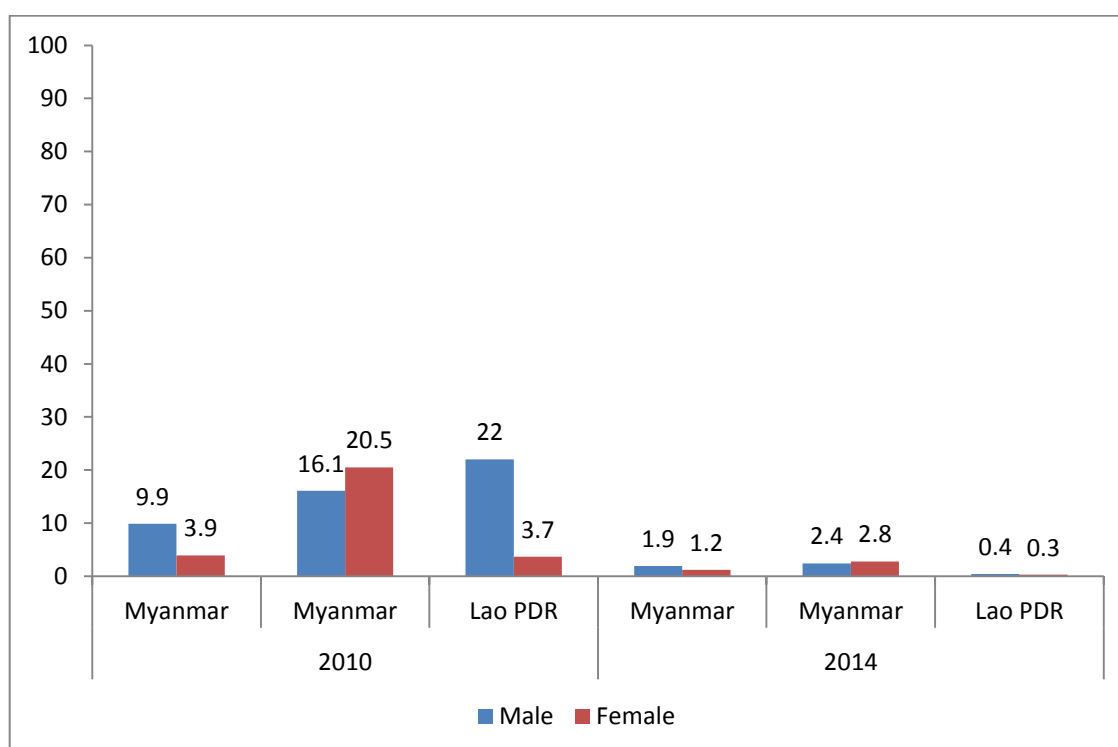
6.3 Care-seeking behavior when experiencing STI-like symptoms

It is noteworthy that the vast majority (93%) of MW with STI-symptoms did not go for diagnosis or treatment, or self-treated. Because the number of the sample with symptoms is so low, the data need to be interpreted with caution. The handful of MW who did go to a clinic or hospital were seen by a doctor and received STI counseling and condoms. Client satisfaction with STI care was high.

6.4 Preferred sources of care when experiencing STI-like symptoms

In 2014, 62% of MW said they would prefer to seek STI care from a government hospital, followed by a health center (18%), NGO clinic (6%), or private clinic (4%). The pattern and preferences over rounds are similar. The proportion who said they would self-treat or not seek treatment for STI symptoms declined over rounds (Figure 6.2).

Figure 6.2: Percent Who Would Self-treat or Not Seek Treatment for STI Symptoms by Nationality and Round



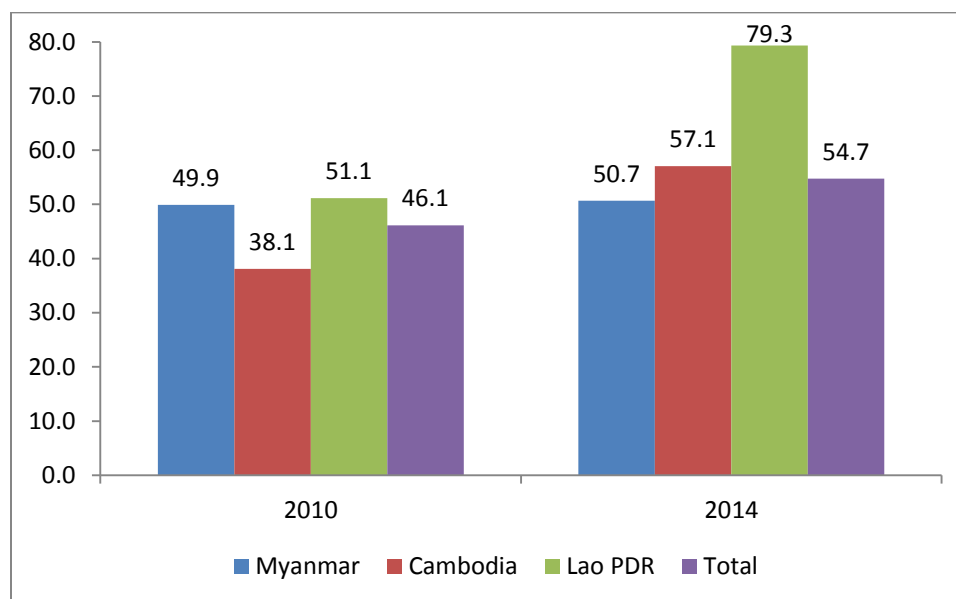
7

Receipt of Information about HIV/AIDS and Condoms

Correct knowledge about HIV/AIDS is important for acquiring a constructive attitude toward HIV and PLHIV, and practicing effective prevention. Constant and consistent Project information about HIV and cost-effectiveness of condoms for prevention should have been a foundation for risk reduction for the population of MW. This chapter presents findings from the Baseline and Follow-up survey for MW exposure to information on HIV/AIDS, VCT, family planning, condoms and migrants' rights, including the channels of delivery of that information.

7.1 Receipt of information from TV, radio and newspaper

MW were asked if they received certain information in the month prior to the interview and by what source. Figure 7.1 shows that significant and increasing percentages of MW watched TV every day, most notably by the Lao MW, but also for an increasing number of Cambodians, especially females.

Figure 7.1 Proportion Who Watched TV Daily by Nationality and Round

Of those who watched TV, nearly all Lao and half of Cambodian MW watched Thai-language broadcasts. MW from Myanmar increasingly watched Burmese-language TV as the proportion increased from under half of viewers in 2010 to over half in 2014. Part of this change is attributable to the expanding channel options for TV viewers. The central language used is a critical factor affecting knowledge of HIV/AIDS. Fuller and Chamrathirong (2008) studied use of language to convey information about health and HIV/STI prevention and found that exposure to and retention of information was highest if communication was in a familiar language for MW. As TV viewing and broadcasts in the native language of the MW has increased, campaigns have added for informational spots to TV broadcasts to maximize exposure.

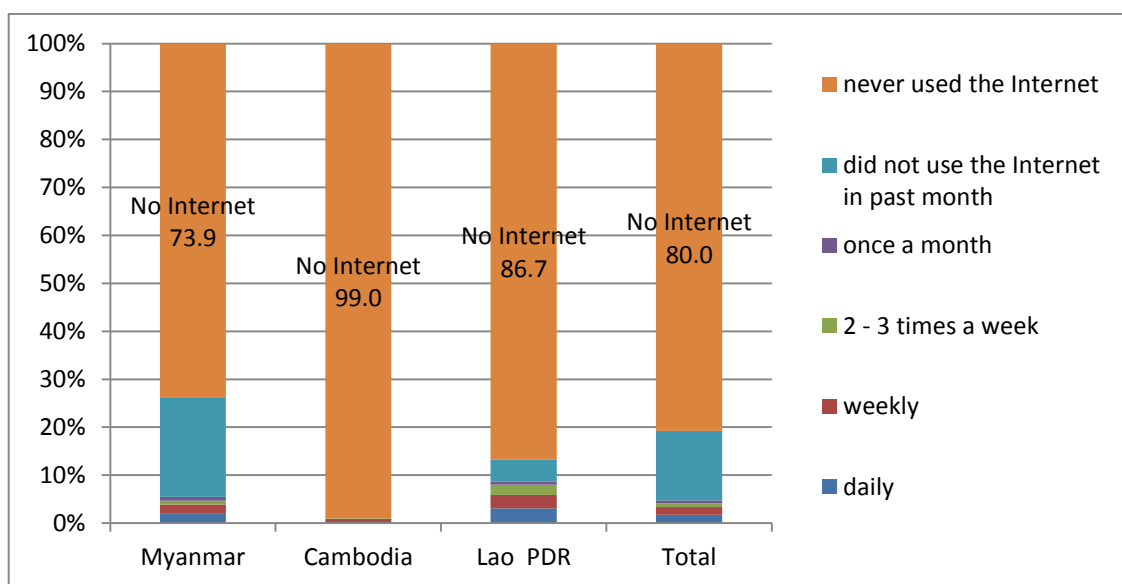
Radio is also a potentially important channel to reach MW with health information. Table 7.1 shows the frequency of radio listening in the month prior to the interview. This evaluation found that radio was not that popular a medium for the MW as only a minority listened daily and two-thirds never did. The levels and patterns of daily listening are similar over rounds. By nationality, more Lao MW listened to radio broadcasts, but the trend in listening to Thai broadcasts increased for all MW (from one-third to one-half who had ever listened to a radio broadcast).

Print material have the advantage of being kept and studied at the reader's leisure and as an on-going reference. However, the low educational level and limited literacy of the MW in this Project was a barrier to effective access to print material, especially when it is in Thai. This evaluation found that, in the past month, over 90% reported never having or hardly ever having read a newspaper, and this did not improve over

rounds. Understandably, Lao MW had more exposure to Thai newspaper than the other nationalities, and males more than females. Burmese MW who read newspapers had access to Burmese-language editions.

It is noteworthy that, for the younger MW, the Internet is becoming a more source of information. Over, coverage was still limited to a small minority as 95% had not used the Internet in 2014 in the prior month. As smart phones become more ubiquitous, it can be expected that the Internet will become a dominant source of news since information can be cost-effectively delivered in multiple languages through this channel (Figure 7.2). As with the other media, Lao MW were more frequent users of the Internet than the MW from Myanmar or Cambodia, respectively. Access was roughly similar for men and women.

Figure 7.2: Frequency of Internet Usage by Nationality, 2014



7.2 Receipt of HIV/AIDS information in the home country prior to coming to Thailand

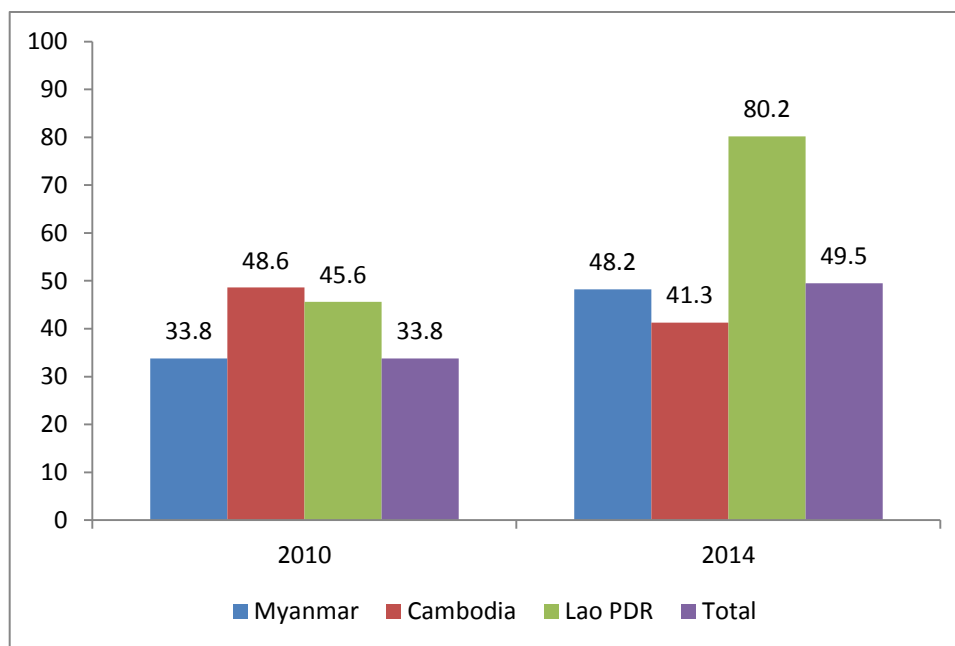
About half of the MW had learned about HIV/AIDS before migrating to Thailand (46% and 52% by round). MW from Cambodia had the most pre-departure awareness, followed by MW from Myanmar. Male MW had greater pre-departure HIV/AIDS knowledge than females.

7.3 Receipt of HIV/AIDS information after migrating to Thailand

Most MW in this evaluation reported increased knowledge of HIV/AIDS after arriving in Thailand. Those who participated in educational campaigns (or had an accompanying family member who did so) reported greater increases in post-arrival

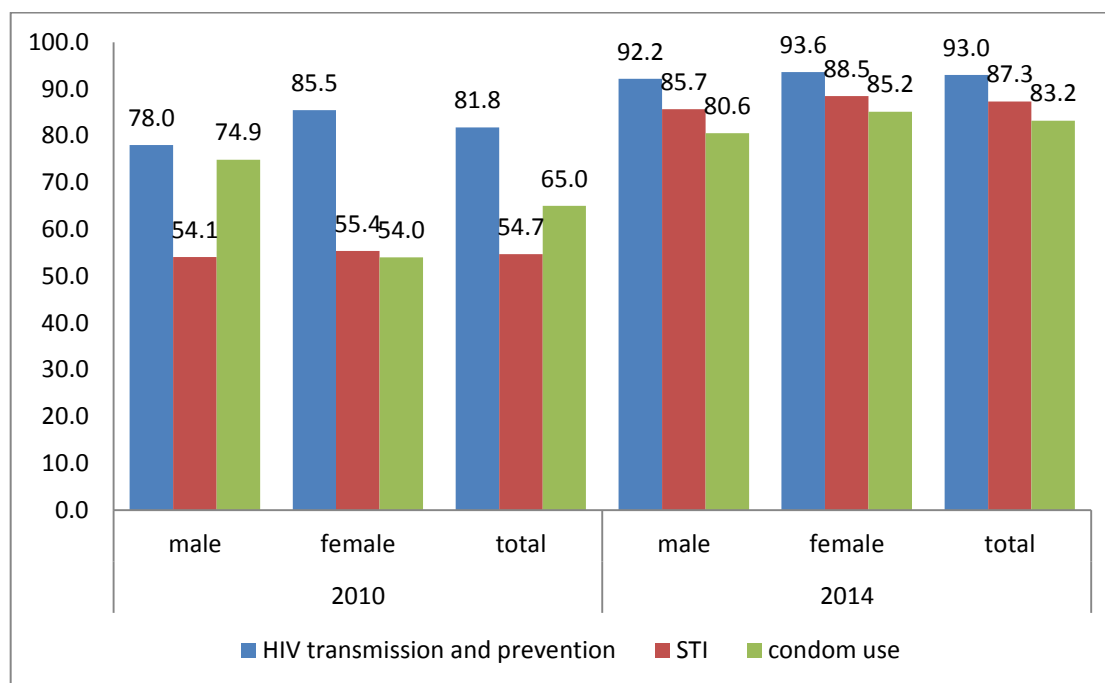
knowledge of STI/HIV/AIDS (34% in 2010 and 50% in 2014 participated in an awareness campaign). There were greater increases in participation for Burmese and Lao MW over rounds, compared to declines for Cambodian MW (Figure 7.3).

Figure 7.3: Proportion Who Received HIV/AIDS Information by Nationality and Round



Information on HIV/AIDS is classified as information on risk of infection and prevention, condom use and STI. Figure 7.4 shows clear increases in receipt of information for males and females over rounds by the following priority: (1) STI; (2) Contact with PLHIV; (3) Managing HIV infection; (4) Condom use; and (5) VCT. Most common sources of information cited by the respondents include RTF, WVFT, and FAR. It is noteworthy that there was less exposure to information about HIV risk and prevention over rounds. There were also declines for exposure to information on MCH, family planning, labor rights, health rights, education rights, and violence against women.

Figure 7.4: Proportion Receiving HIV/AIDS Information by Sex, Type of Information (Top 3) and Round

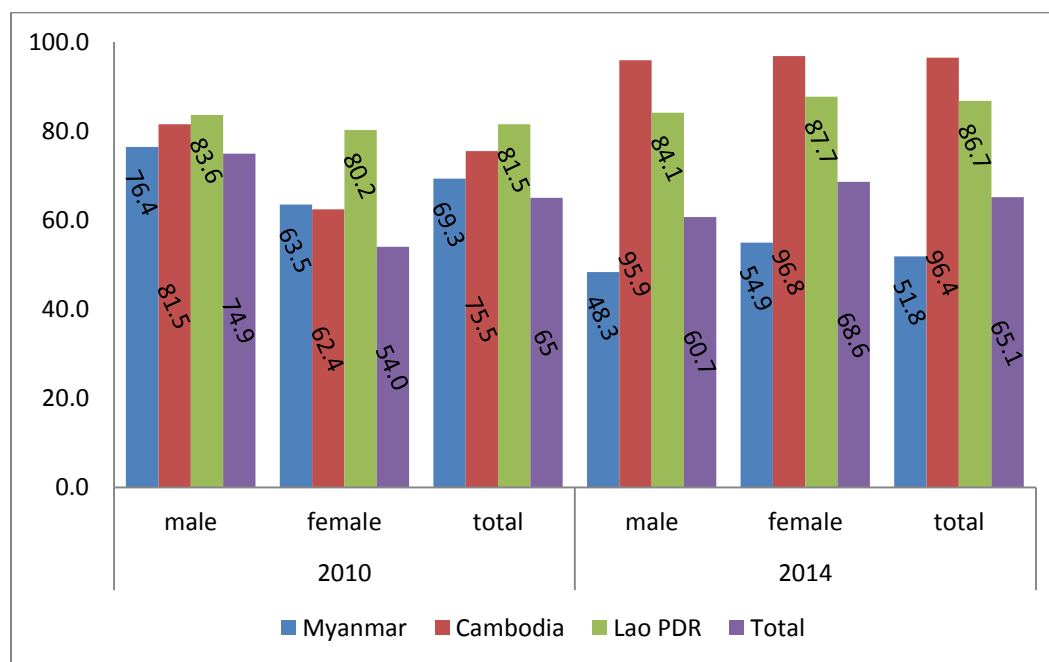


By nationality, the Cambodian MW received the most comprehensive range of HIV/AIDS information: Nearly all received information on STI, HIV risk, prevention and condom use, over 80% received information on contact with PLHIV, and over half received information about managing HIV infection. Lao MW had the next highest level of exposure to HIV/AIDS information with 80% receiving HIV prevention and condom use, and over half receiving information on STI and contact with PLHIV and managing HIV infection. Over half of MW from Myanmar received information about HIV risk, prevention, STI and condoms. Important sources of HIV/AIDS information include private clinics, MHV and MHW.

7.4 Receipt of information about condoms

This evaluation found that most MW had received information about condoms, as about two-thirds were exposed to condom education, as reported in both survey rounds. The Cambodian and Lao MW had somewhat more exposure to condom information than their Myanmar counterparts, and knowledge increased over rounds. By contrast, exposure to condom information for Burmese MW covered only about half of respondents and declined over rounds (Figure 7.5).

Figure 7.5: Proportion Receiving Information about Condoms by Sex, Nationality and Round

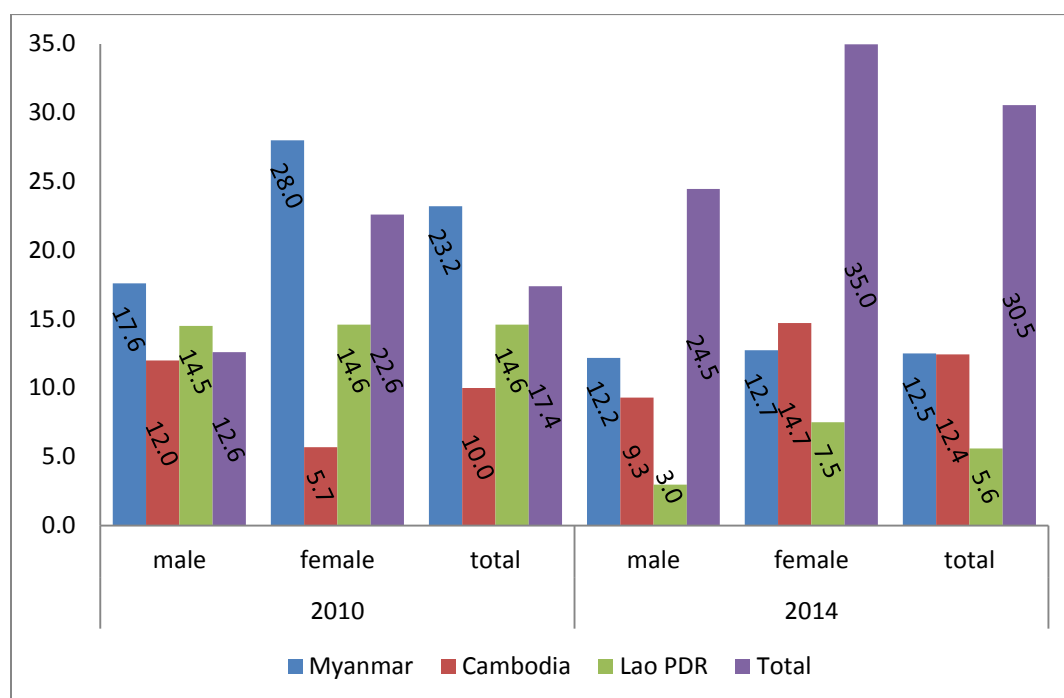


An interesting trend is that, over rounds, more female MW were being exposed to information on condoms than males as exposure for males actually declined, and this is most apparent for Cambodian and Lao women. When combined however, the overall trend across rounds is constant. Sources of condom education included focus group discussions, training, lectures, brochures, booklets, and posters. More Burmese MW received their information from focus group discussions, while Cambodian and Lao reported more exposure to lectures and educational print media. Nearly all MW reported receiving condom information from private clinics. MHV and MHW are more important sources of condom information for Burmese MW while NGO outreach staff are important for Cambodian and Lao MW.

7.5 Receipt of information about VCT services

Effective management of HIV infection requires early detection. Also, persons with risk should know their serostatus. Further, VCT provides information and access to a wide range of health services for the MW. The evaluation asked respondents about knowledge and access to VCT. Knowledge of VCT increased over rounds, especially for Cambodian and Lao MW (Figure 7.6).

Figure 7.6: Proportion Receiving Information about VCT Services by Sex, Nationality and Round



Sources of information include focus group discussion, training and lectures. More Burmese received VCT information from focus group discussion, while Cambodian and Lao MW received more information from training and lectures. Private clinics were also an important source of VCT information, as were MHV, MHW and NGO staff.

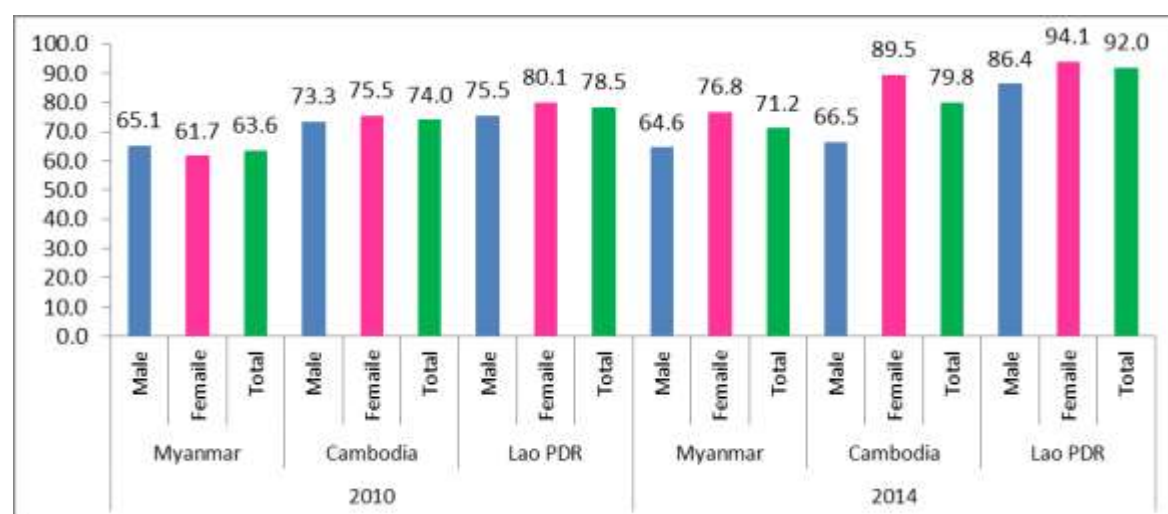
8

Sex Behavior and Condom Use

Many studies have shown that favorable knowledge and attitudes about safe sex and condoms does not always predict prevention behavior. *Thus, evaluators cannot rely solely on improvements in knowledge and attitude to gauge a program's success in prevention of HIV and STI.* Therefore, a more reliable measure of prevention impact is self-reported sex behavior and condom use. This chapter presents data from the Baseline and Follow-up surveys on sex behavior and condom use of the MW, types of sex partner, and reasons for not using condoms (see Table 8.1 in Appendix A).

8.1 History of sex

The proportion of MW who ever had sex increased from 63% to 75% over rounds. By nationality the proportions by round are 78% and 92% for Lao MW, 74% and 80% for Cambodian, and 64% and 71% for Burmese MW (Figure 8.1).

Figure 8.1: Percent Who Ever Had Sex by Nationality and Round

8.2 Age at first sex

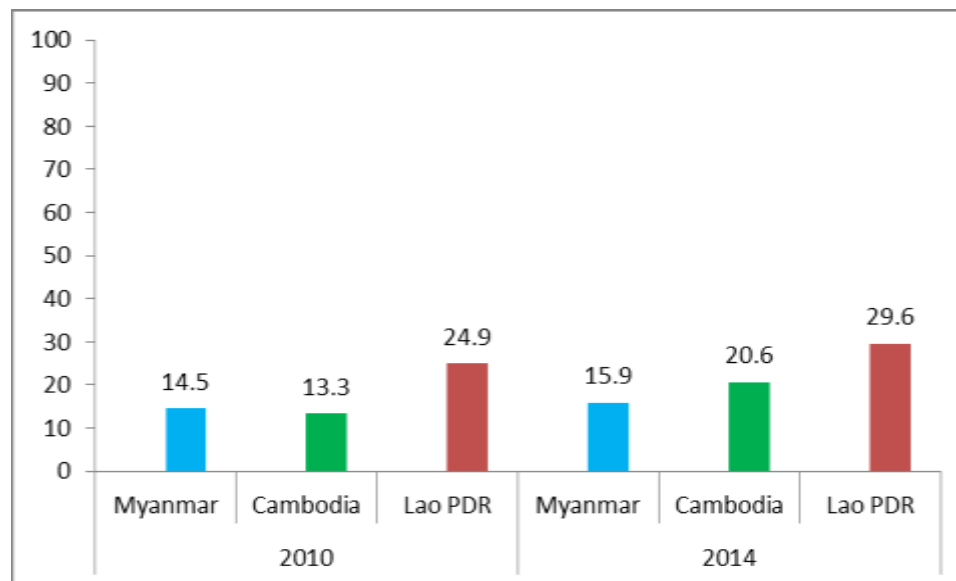
Average age at first sex remained constant over rounds at 21 years and was similar for all three nationalities.

8.3 Condom use by type of partner

8.3.1 Spouse/regular sex partner

Among those MW who ever had sex, most had a spouse or regular partner, and the proportion increased from 83% in 2010 to 89% in 2014. By nationality the proportions are 85 to 90% for MW from Myanmar, 66 to 89% for Cambodians, and 85 to 90% for Lao MW. More (90%) female MW reported having a spouse/regular partner than males in both rounds. Ever-use of condoms with their regular partner increased from 11% to 19% over rounds. By nationality, the increase was 14 to 16% for Burmese MW, 13 to 21% for Cambodian MW, and 25 to 30% for Lao MW (Figure 8.2).

Figure 8.2: Percent Ever Using a Condom with their Spouse/Regular Partner by Nationality and Round



The reasons for condom use with their regular partner were similar across nationalities and include prevention of pregnancy (from 82% to 83% over rounds), and prevention of STI/HIV (10% to 15% over rounds). More female MW cited prevention of STI/HIV as their motivation than men (from 3 to 18% for Burmese women, 0 to 13% for Cambodian women, and from 43% to 32% for Lao women).

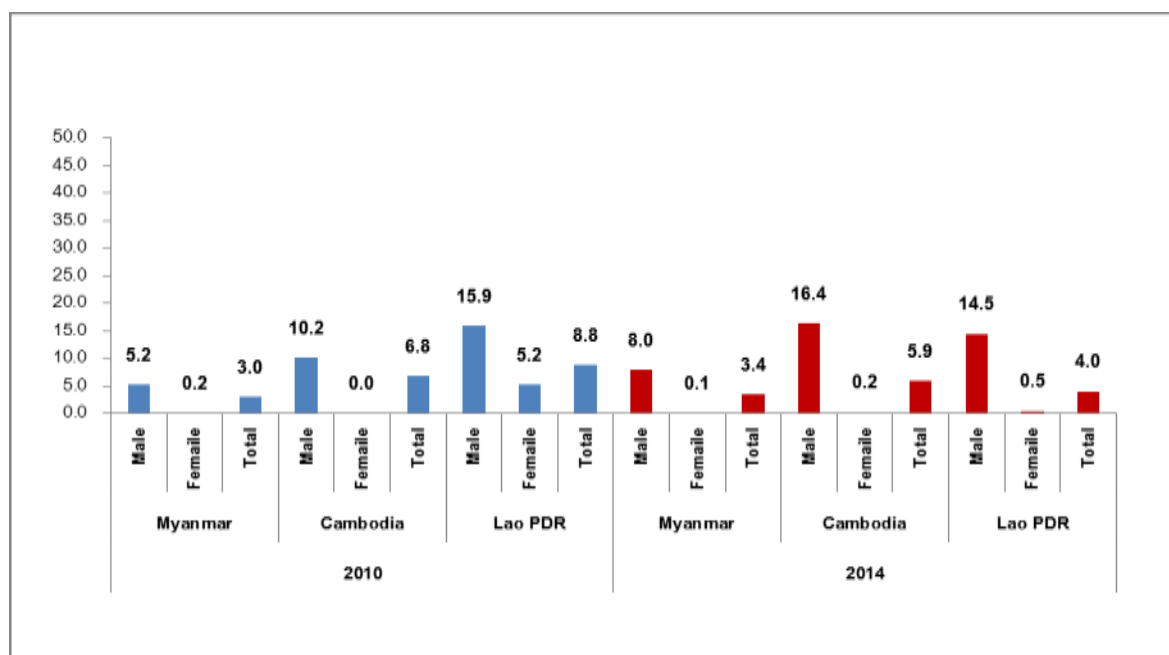
Reasons for not using a condom with their regular partner include trust of one's partner, not necessary, and already using another method of contraception.

8.3.2 Non-regular sex partner

MW who ever had sex were asked if they had sex with a non-regular partner in the 12 months prior to the interview. Over rounds, the proportion who had had sex with a non-regular was constant at 4%. More male than female MW reported having a non-regular sex partner in the past year and, by nationality the proportions increased from 5 to 8% for MW from Myanmar, 10 to 16% for Cambodian MW, and declined slightly from 16 to 14% for Lao MW.

More single MW over both rounds reported having a non-regular sex partner than their married counterparts, especially male MW. By nationality the proportion for single MW increased from 22 to 42% over rounds for MW from Myanmar, and 16 to 51% for Cambodian MW. About half of the single, male Lao MW reported a non-regular sex partner in the previous year, at both rounds (Figure 8.3).

Figure 8.3: Percent Reporting Sex with a Non-Regular Partner in the Past 12 Months by Nationality and Round

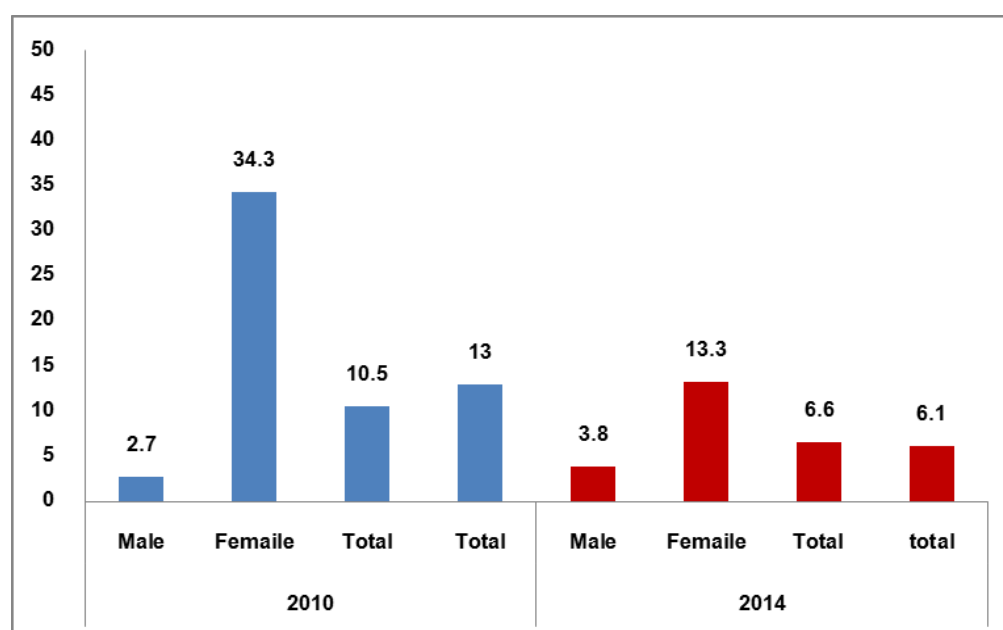


The average number of non-regular sex partners in the past year for male MW increased from one to two over rounds for all three nationalities.

8.3.3 Sex worker

Both survey rounds found that Cambodian male MW were more likely to have had sex with a sex worker in the past 12 months than the Lao or Burmese MW, but the proportion declined from 34% to 13% over rounds. Male Lao MW who reported buying sex also declined, from 10% to 7% over rounds. Burmese MW had the least history of buying sex in the past year: 3% and 4% (Figure 8.4). *These differences could reflect the different proportions of single men, occupation or living conditions among the three groups as opposed to social norms.*

Figure 8.4 Percent Who Had Sex with a Sex Worker in the Past 12 Months by Nationality and Round



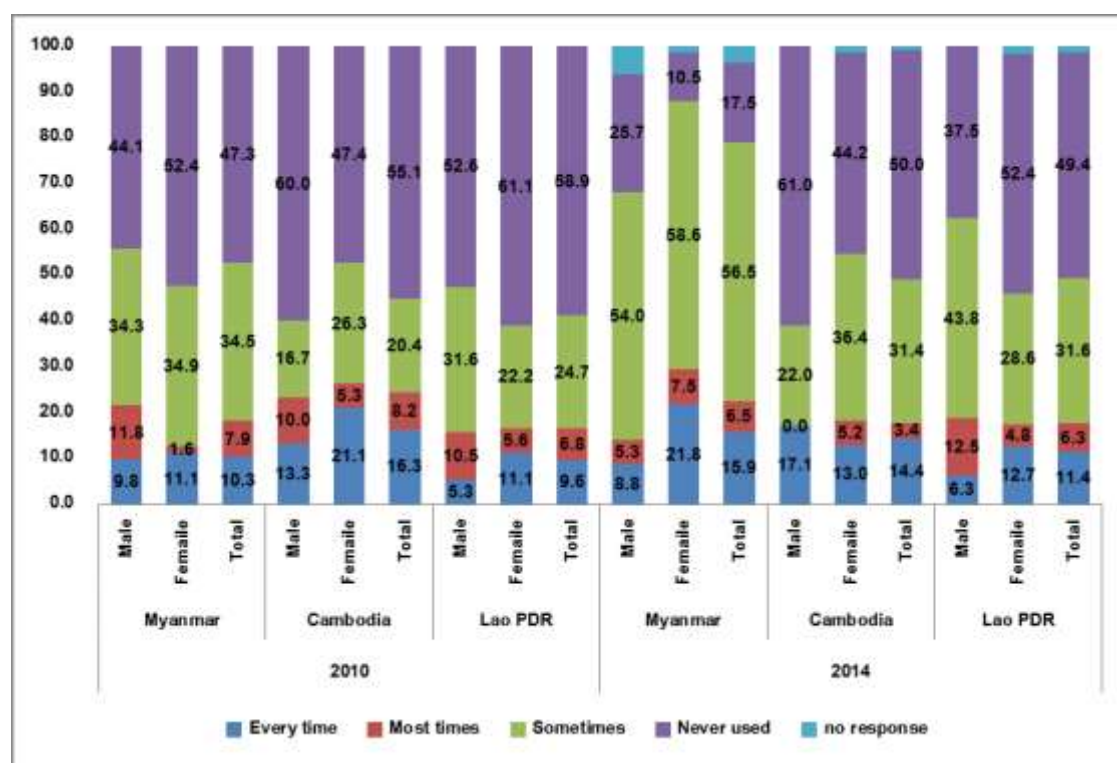
8.4 Consistent Condom Use in the Past 12 Months

8.4.1 Spouse/regular partner

The prevalence of never using a condom with a regular partner or spouse in the prior 12 months declined over rounds from 44% to 32% and for all nationalities. Those who had used condoms reported only using them occasionally (from 31% to 45% over rounds). By nationality, those male Burmese reporting inconsistent condom use increased from 34% to 54%, while their female counterparts reported an increased in inconsistent use from 35% to 59% (Figure 8.5).

The proportion who reported always using condoms with their regular partner/spouse increased over rounds from 13% to 15%. In the Baseline Survey, highest always-use was reported by the Cambodian MW (16%) followed by MW from Myanmar and Lao PDR (10%). In the Follow-up round, highest use was among the MW from Myanmar (16%), followed by Cambodian (14%) and Lao (11%) MW (Figure 8.5).

Figure 8.5: Consistency of Condom Use with a Spouse/Regular Partner by Nationality and Round



8.4.2 Non-regular partner

The proportion of male MW reporting never using condoms with a non-regular partner in the past 12 months declined by half from 42% to 21% across rounds. By nationality, the MW from Myanmar reported a decline in never-use from 39% to 24% over rounds, and Cambodians reported 11% to zero never-use over rounds. Consistent (always) use of a condom with a non-regular partner increased over rounds from 35% to 47%. By nationality, the increase was 32% to 48% for Burmese MW, but Cambodian MW reported a decrease in consistent use from 80% to 60%.

8.4.3 Sex worker

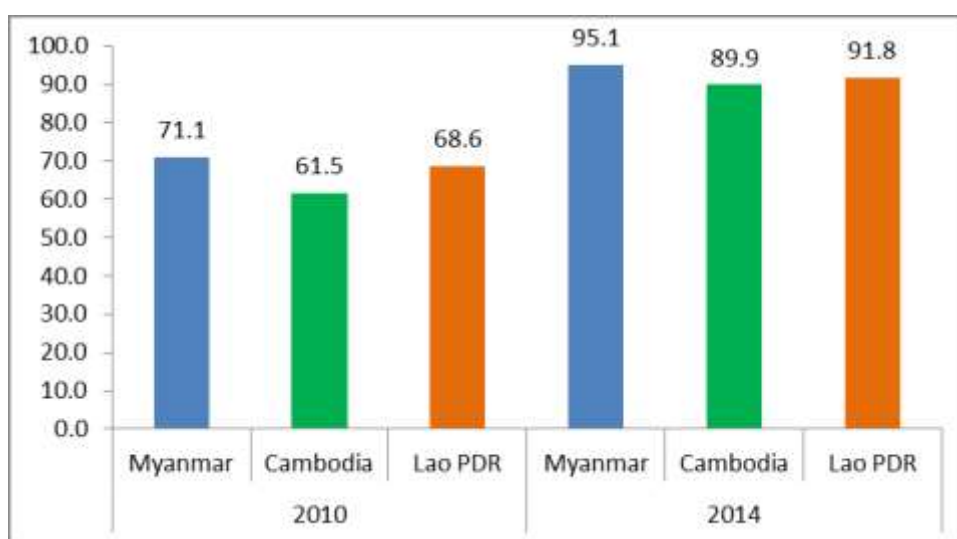
Male MW who had sex with a sex worker in the past 12 months reporting using a condom for every episode increased from 75% to 79% over rounds. By nationality, always-use was about constant for MW from Myanmar (76% and 75%), and increased for Cambodian MW (75% to 80%). The number of Lao MW with non-regular or commercial sex partners was too low to provide meaningful results.

8.5 Condom use at last sex by type of partner

8.5.1 Spouse/regular partner

Of those who ever used condoms in the past year, condom use at last sex with a regular partner/spouse increased markedly over rounds, from 69% to 92% and for all nationalities and both sexes. For male MW, the increase was from 71% to 95%, while for females the increase was from 62% to 90% (Figure 8.6).

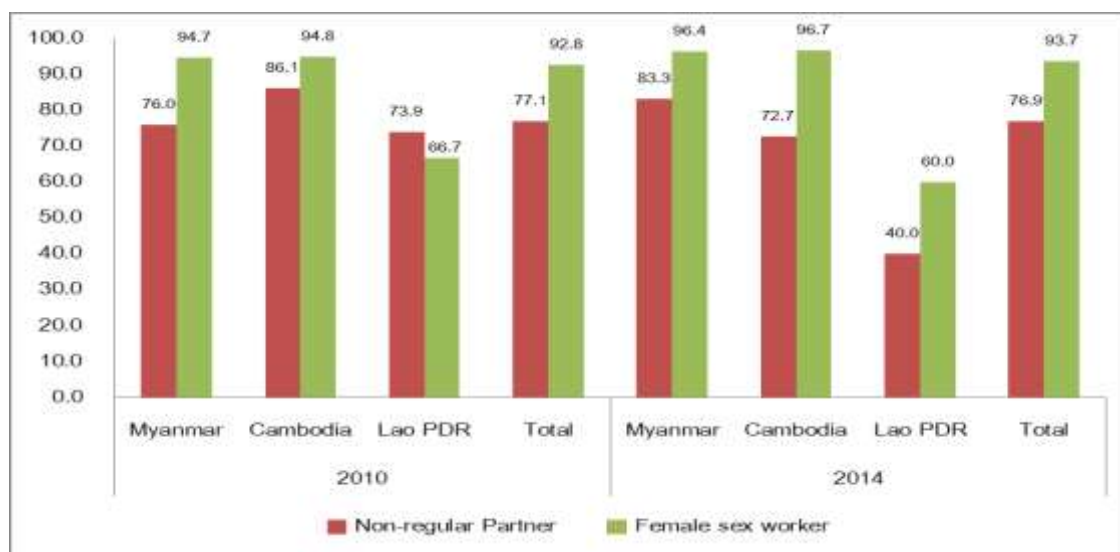
Figure 8.6: Condom Use at Last Sex with a Spouse/Regular Partner by Round



8.5.2 Non-regular partner and sex worker

Of those male MW who ever used a condom with a non-regular partner, condom use at last sex with a non-regular partner was constant at 77% (Figure 8.7). However, this average masks differences by nationality. Male Burmese MW reported increased condom use at last sex from 76% to 83%, but Cambodian and Lao MW reported decreases, from 86% to 73%, and 74% to 40% respectively (though the N for Lao respondents is very low). For last sex with a sex worker, the corresponding percentages of condom use are 93% and 94% over rounds for all male MW (who had sex with a sex worker in the past 12 months and had ever used condoms with a sex worker). By nationality the proportions reporting condom use at last commercial sex is roughly constant over rounds.

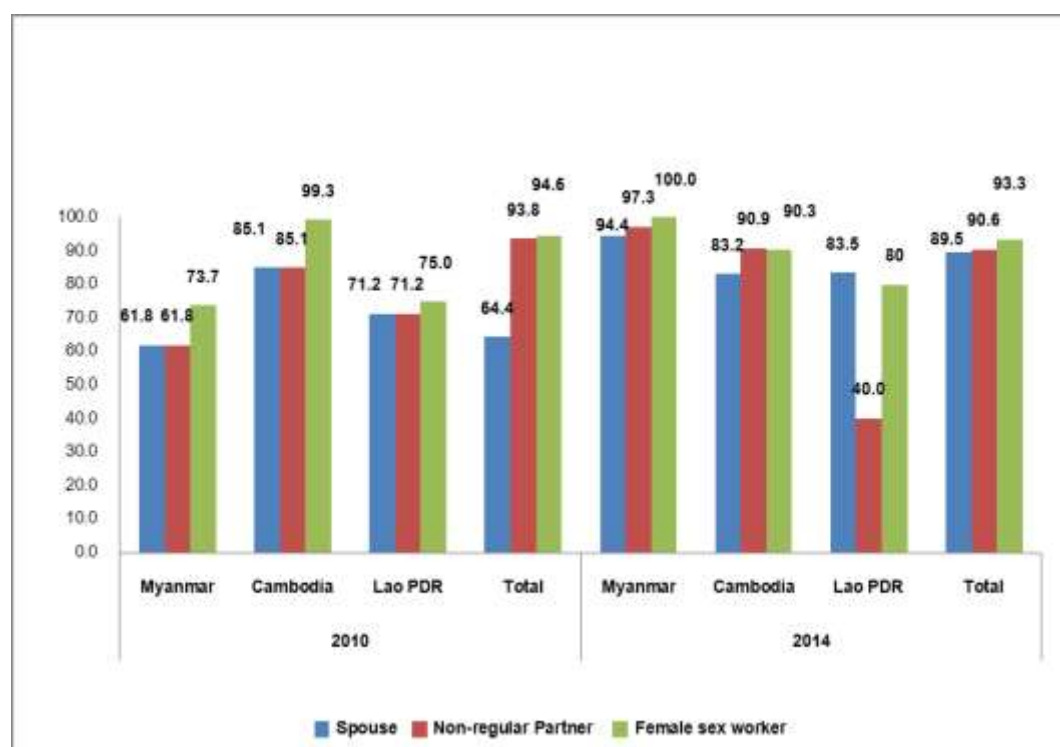
Figure 8.7: Condom Use at Last Sex with a Non-regular Partner and Sex Worker by Nationality and Round



8.6 Access to condoms

The proportion having condoms available when needed for sex with a spouse/regular partner increased from 64% to 90% over rounds. However, the corresponding percentages for sex with a sex worker or non-regular partner remained constant at just over 90% by round (Figure 8.8).

Figure 8.8: Having a Condom Available when Needed by Type of Partner, Nationality and Round

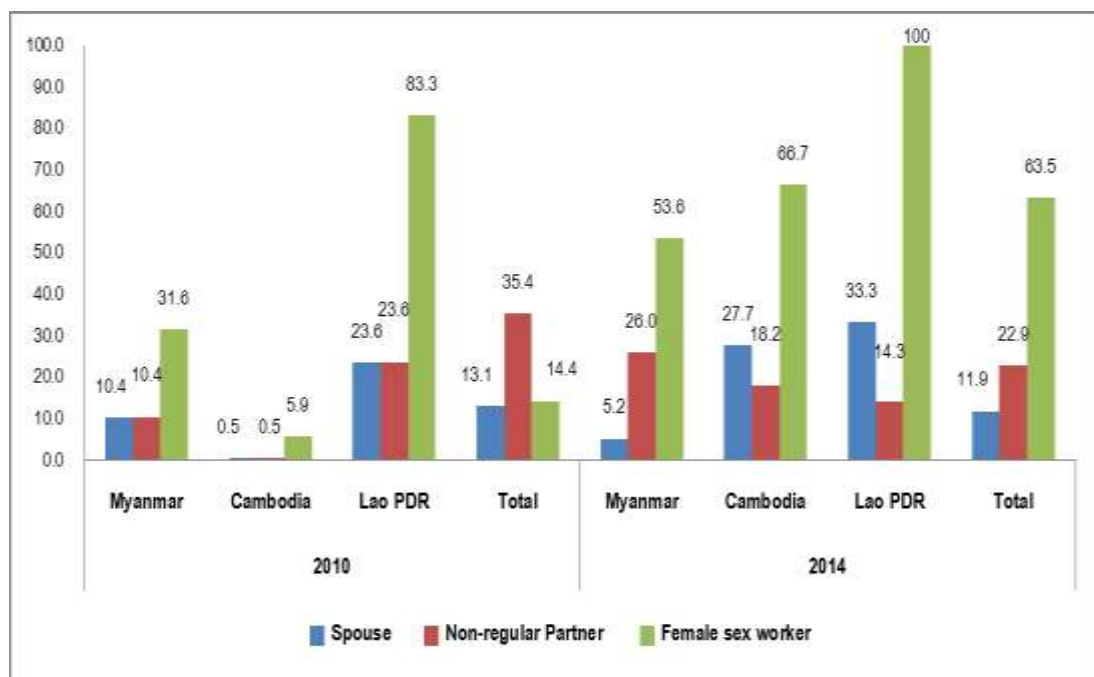


8.7 Reasons for not using condoms

8.7.1 Use of drugs before sex

If the male MW used drugs before sex it was almost always alcohol, and this did not change over rounds or among nationalities. This evaluation found that male MW were more likely to have used drugs/intoxicants before sex with a sex worker than with one's spouse/regular partner, and the proportion increased sharply over rounds from 14% to 64%, by nationality, from 32% to 54% for MW from Myanmar, and from 6% to 67% for Cambodian MW (Figure 8.9).

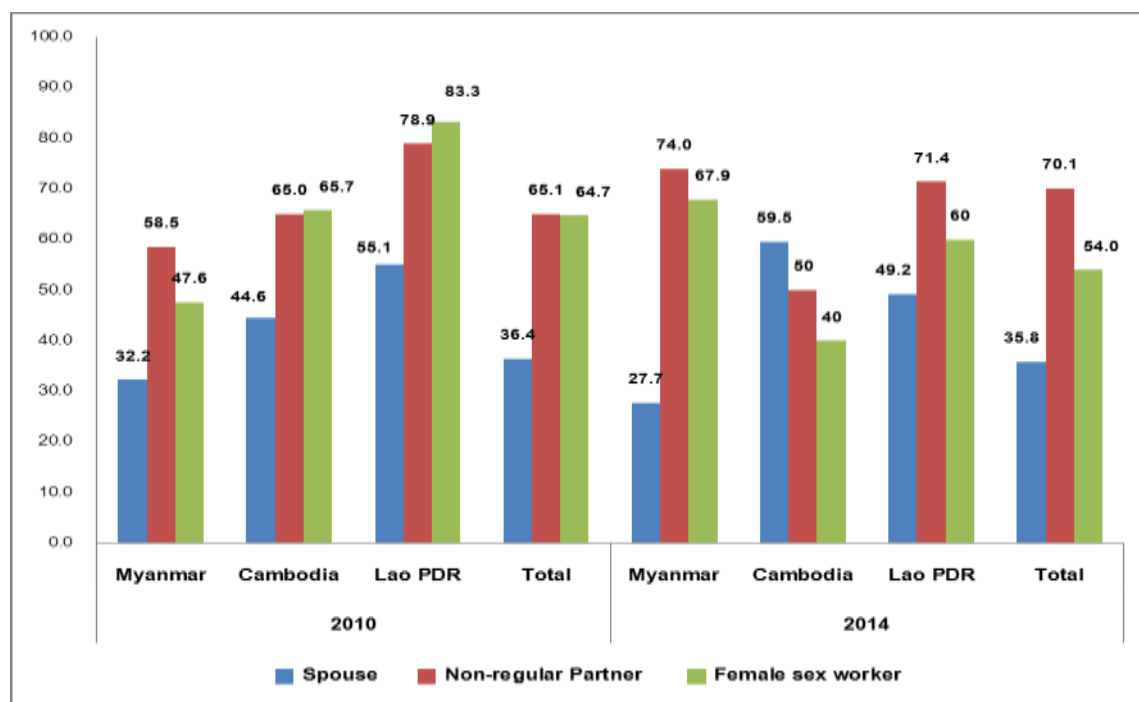
Figure 8.9: Percent Who Used Drugs/intoxicants Before Sex by Type of Partner, Nationality and Round



8.7.2 Attitudes toward condom use

Male MW were asked if they thought condoms reduce the pleasure of sex by type of partner. Nearly twice the proportion of MW felt that condoms reduce pleasure of sex with a non-regular partner or sex worker compared to marital sex (65% versus 36%) and this differential held up over rounds, with the exception of Cambodian MW (Figure 8.10). In the Baseline, 44% of Cambodian MW said that condoms reduce pleasure of sex with their spouse, and this actually increased to 60% in the Follow-up. Roughly steady proportions of Burmese and Lao MW over rounds felt that condoms reduce pleasure of marital sex (one-third and one-half respectively).

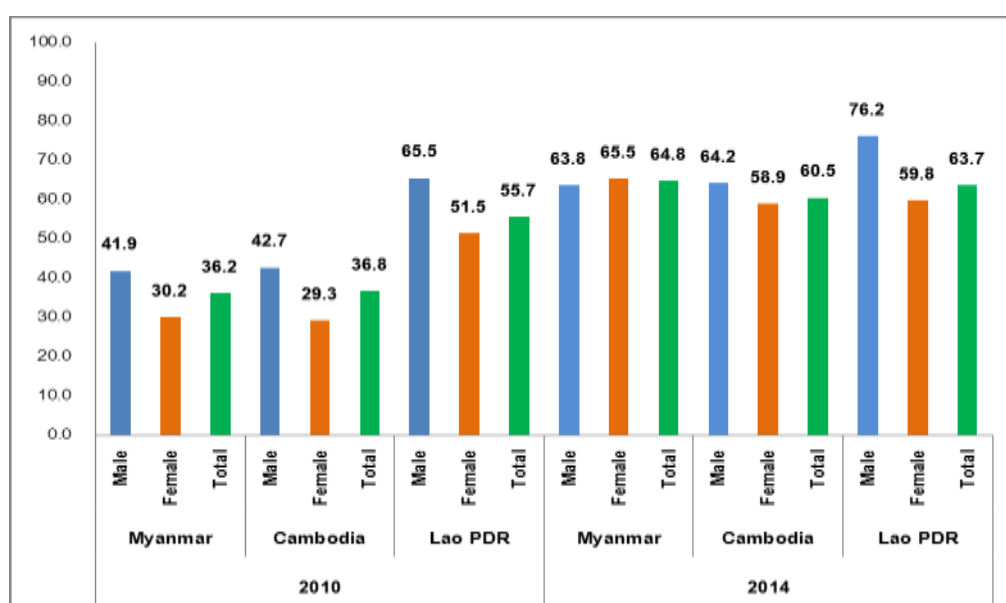
Figure 8.10: Percent Who Feel that Condoms Reduce Pleasure of Sex by Type of Partner, Nationality and Round



8.7.3 Confidence in ability to negotiate condom use with one's partner

Confidence in ability to persuade one's spouse/regular partner to use a condom increased significantly over rounds for all three nationalities and for both sexes (Figure 8.11). Overall, the increase was from 38% to 64% over rounds and greatest for the MW from Myanmar, 37% to 60% for Cambodians, and 56% to 64% for Lao MW.

Figure 8.11: Confidence in Ability to Negotiate Condom Use with Spouse/Regular Partner by Nationality and Round

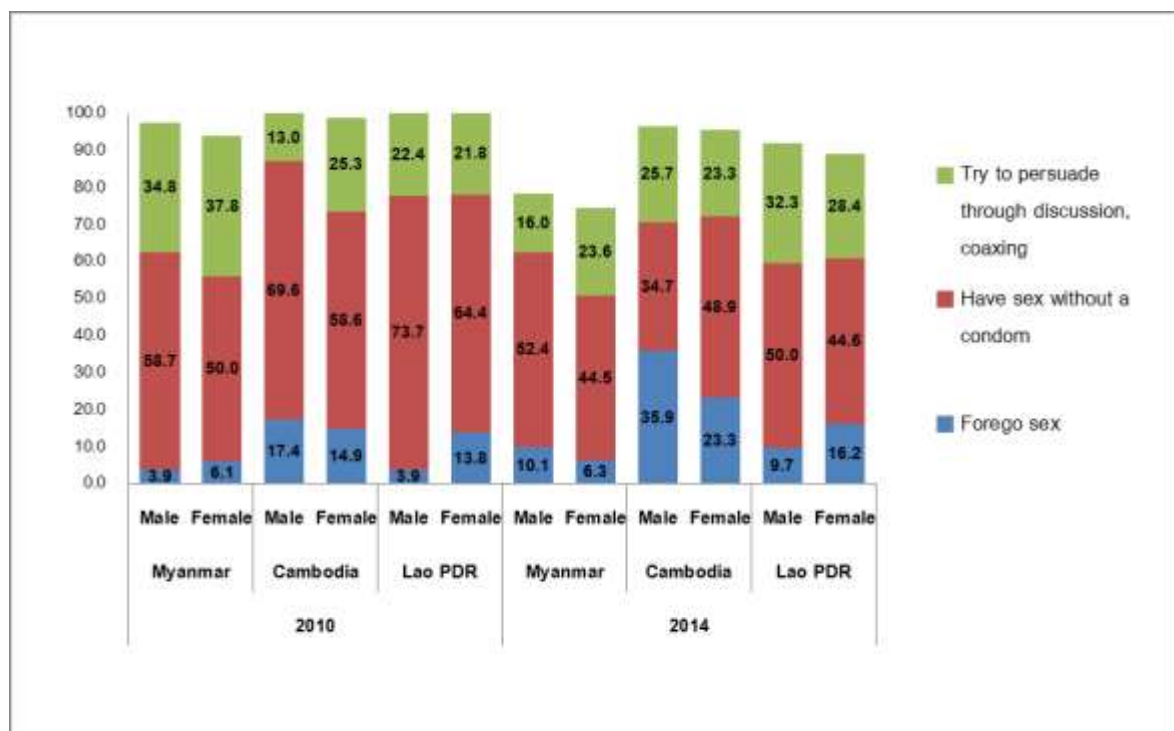


For sex with a non-regular partner, male Burmese MW had increased confidence in negotiating condom use over rounds (80% to 90%), as did Cambodian MW (72% to 90%). For commercial sex, confidence in negotiating condom use increased from 80% to 89% for male MW from Myanmar and from 79% to 83% for Cambodian MW.

8.7.4 Condom negotiation skills by type of partner

The samples of MW were asked what a person should do if their partner refused to use a condom. For sex with a spouse or regular partner, over half would consent to unsafe sex in the Baseline Survey round, but this declined over rounds for all the groups and both sexes (Figure 8.12).

Figure 8.12 Condom Use Negotiation by Strategy, Sex, Nationality and Round



The proportion who would refuse condom-less sex also increased over rounds for both sexes and all three nationalities. When males were asked about sex with a sex worker, the percent who would consent to have unsafe sex declined from 22% to 6% if the sex worker refused to use condoms, while the proportion who would try to persuade the sex worker to use condoms tripled from 12% to 36%.

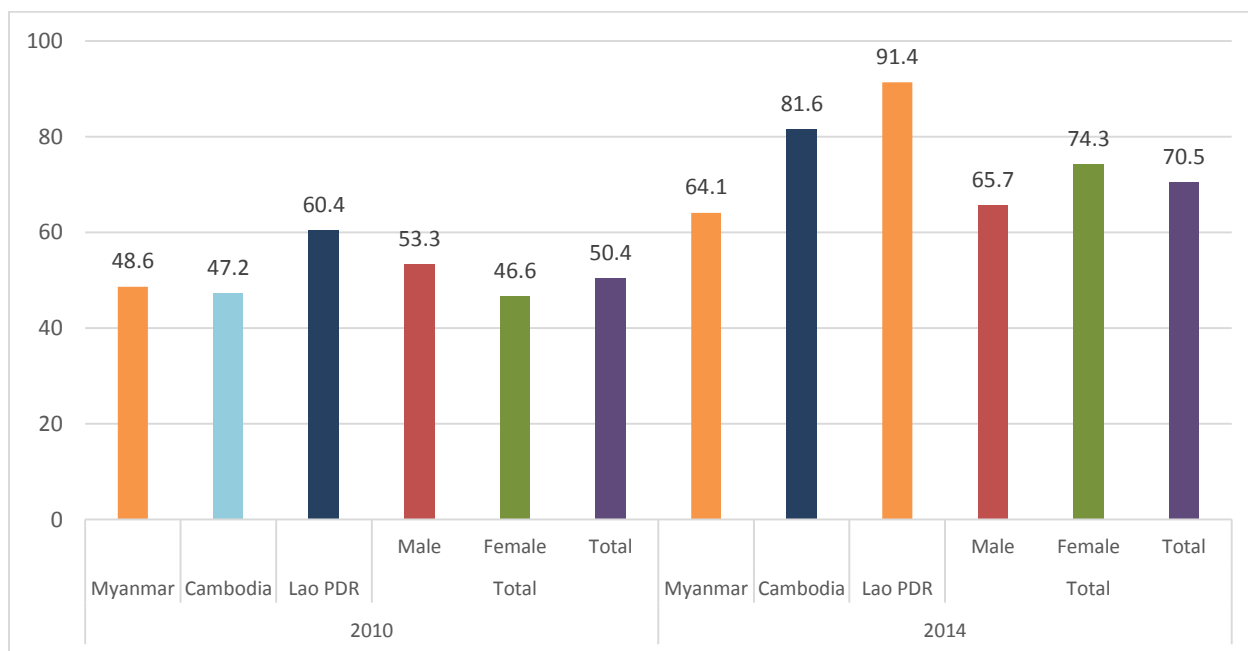
9

Voluntary Counseling and Testing (VCT)

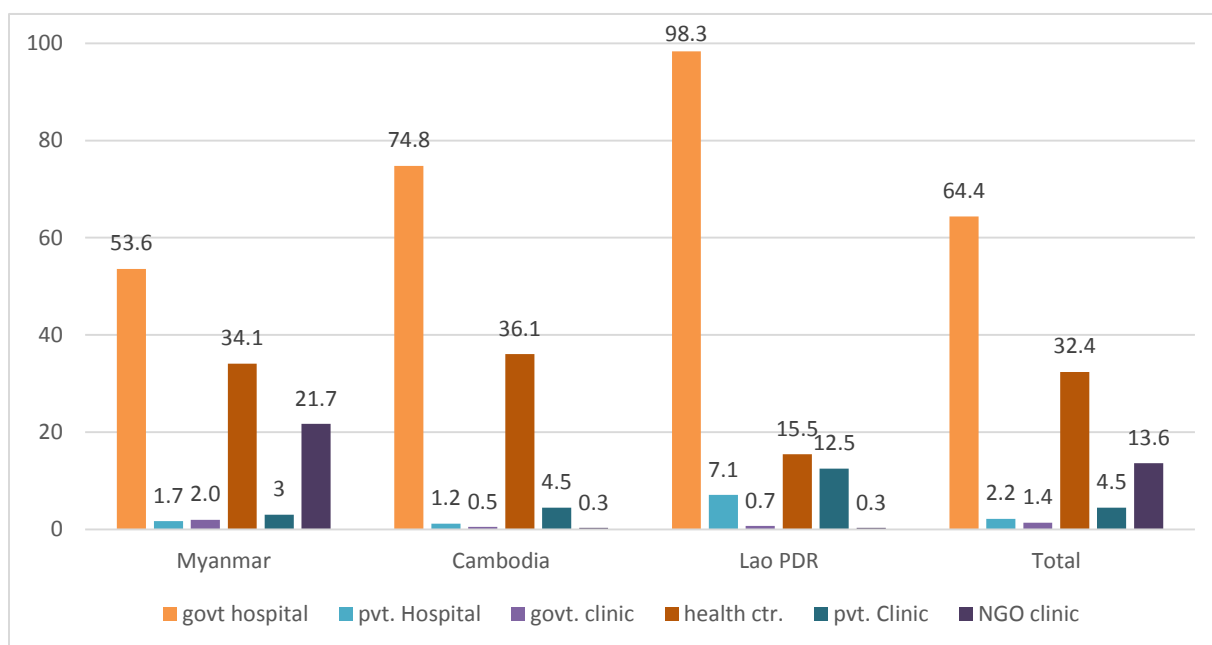
Access to HIV testing and knowing the results is an important PHAMIT service indicator for the target population of MW. The Project worked with provincial and district hospitals to create client-friendly VCT services for MW, in part, by providing education and counseling in the language which the MW could understand easily, and to arrange services so that they were convenient and tailored to the socio-cultural context of the migrant community. This chapter presents data on options and access to VCT for the MW samples and how these changed over the 2010 and 2014 survey rounds.

9.1 Knowledge of a VCT outlet

In order to use VCT when needed, the MW first need to know what it is and where it is available. Knowledge of a VCT outlet increased from 50% to 70% among MW over rounds, but female awareness increased more than male awareness (Figure 9.1). Lao MW had the highest awareness of a VCT site, followed by Cambodian and Burmese MW (91%, 82% and 64% respectively).

Figure 9.1 Percent Who Know a VCT Outlet by Sex, Nationality and Round

MW who knew of a VCT site were asked to name the types of sites in the vicinity. About two-thirds (64%) cited a government hospital as having VCT, one-third cited a health center, while 14% mentioned private clinics (Figure 9.2). Nearly all Lao named a government hospital as a VCT outlet compared to 75% for Cambodian MW, and 54% of MW from Myanmar. It is noteworthy that only the MW from Myanmar cited a private clinic as a source for VCT.

Figure 9.2: Types of VCT Cited in 2014 by Nationality

9.2 History of visiting a VCT service

This evaluation found that, in 2014, over one-third (38%) of MW had been tested for HIV (34% of males and 40% of females), and this represents a five-fold increase over the proportion in 2010 (Figure 9.3). An increased proportion of Burmese and Cambodian MW reported having been tested for HIV, though Lao MW reported a decline over rounds. Of those who had been tested, the latest VCT site for three-fourths of MW was a government hospital, followed by 16% reporting a health center (Figure 9.4). Only one-quarter had been tested in the year prior to the interview.

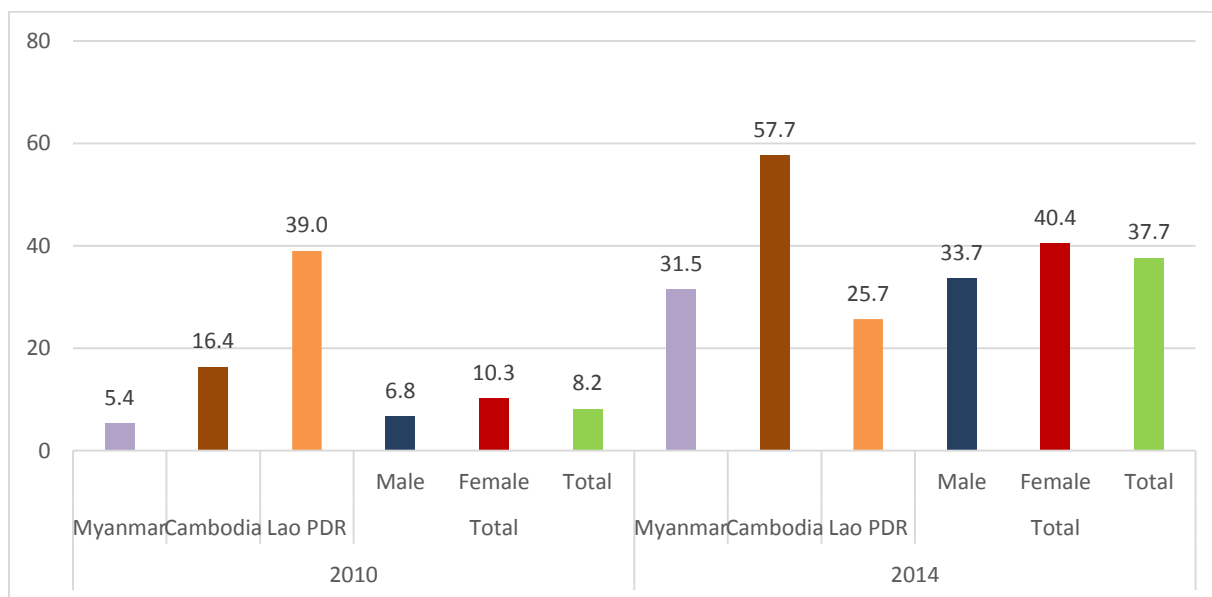
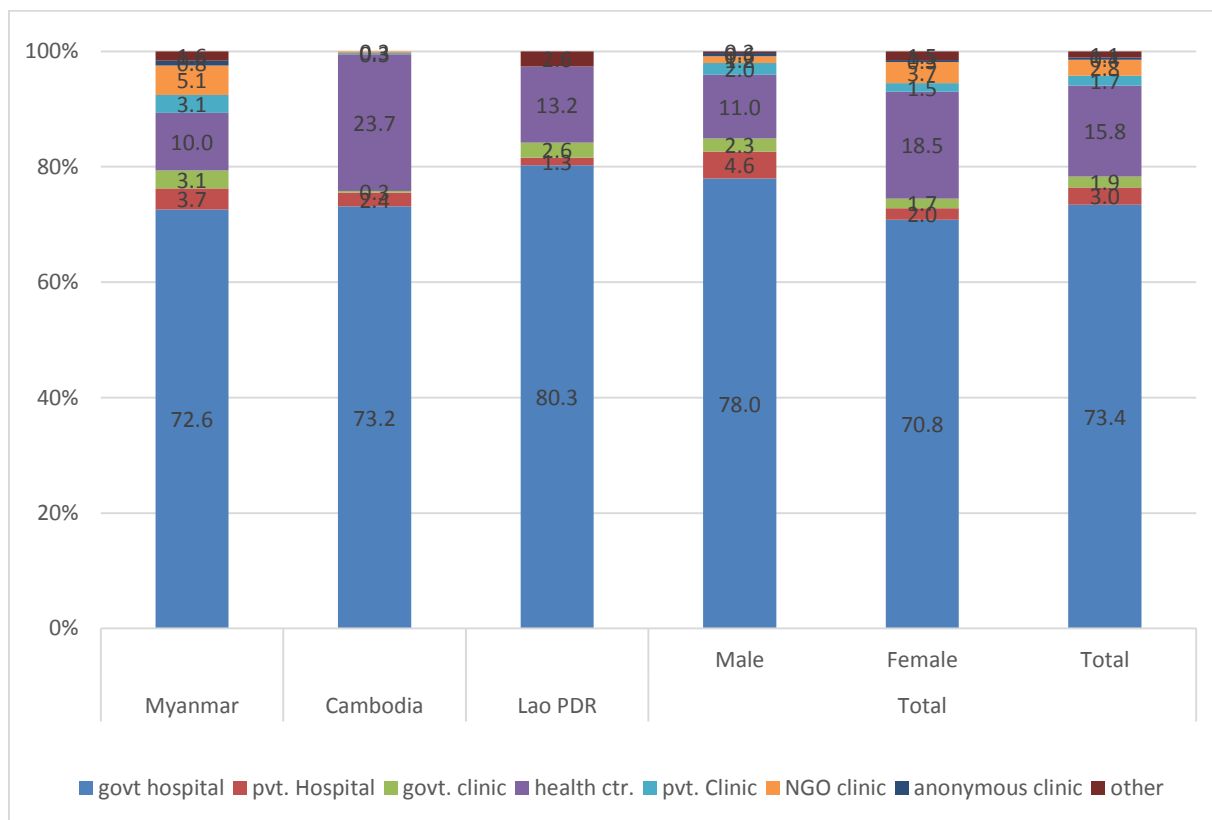
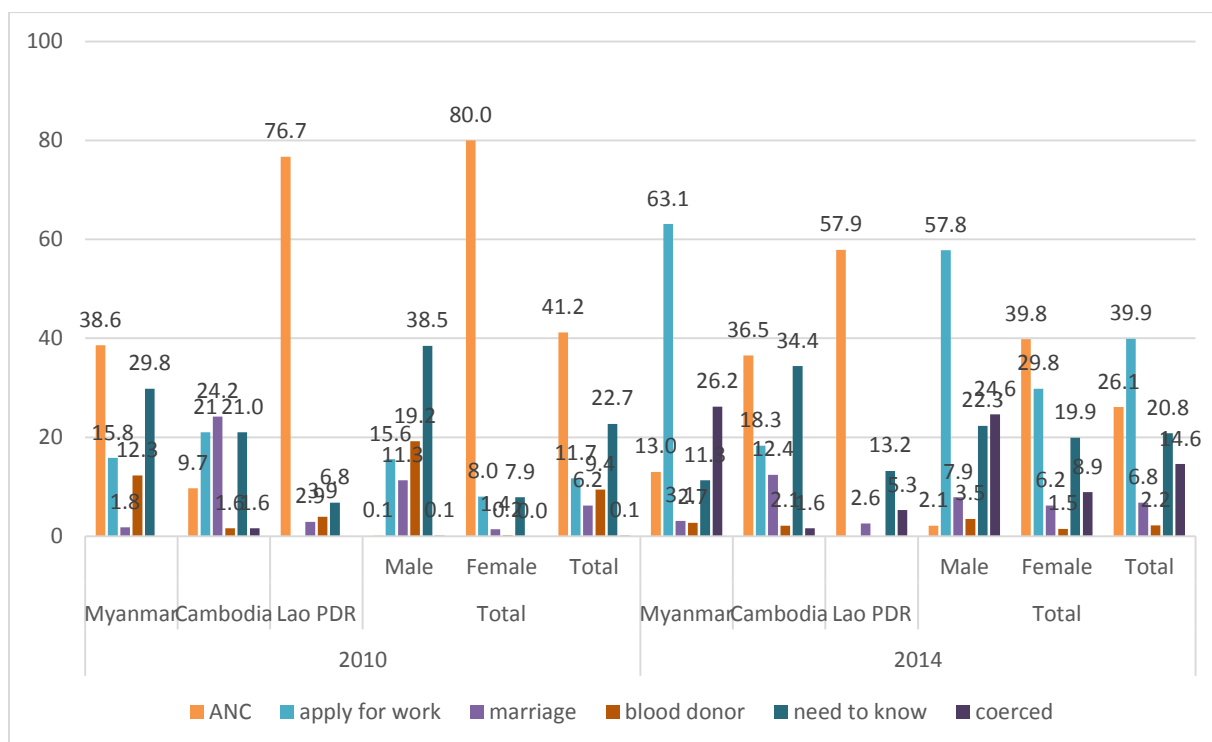
Figure 9.3: Percent Ever Being Tested for HIV by Nationality, Sex and Round**Figure 9.4: Type of VCT Outlet in 2014 by Nationality and Sex**

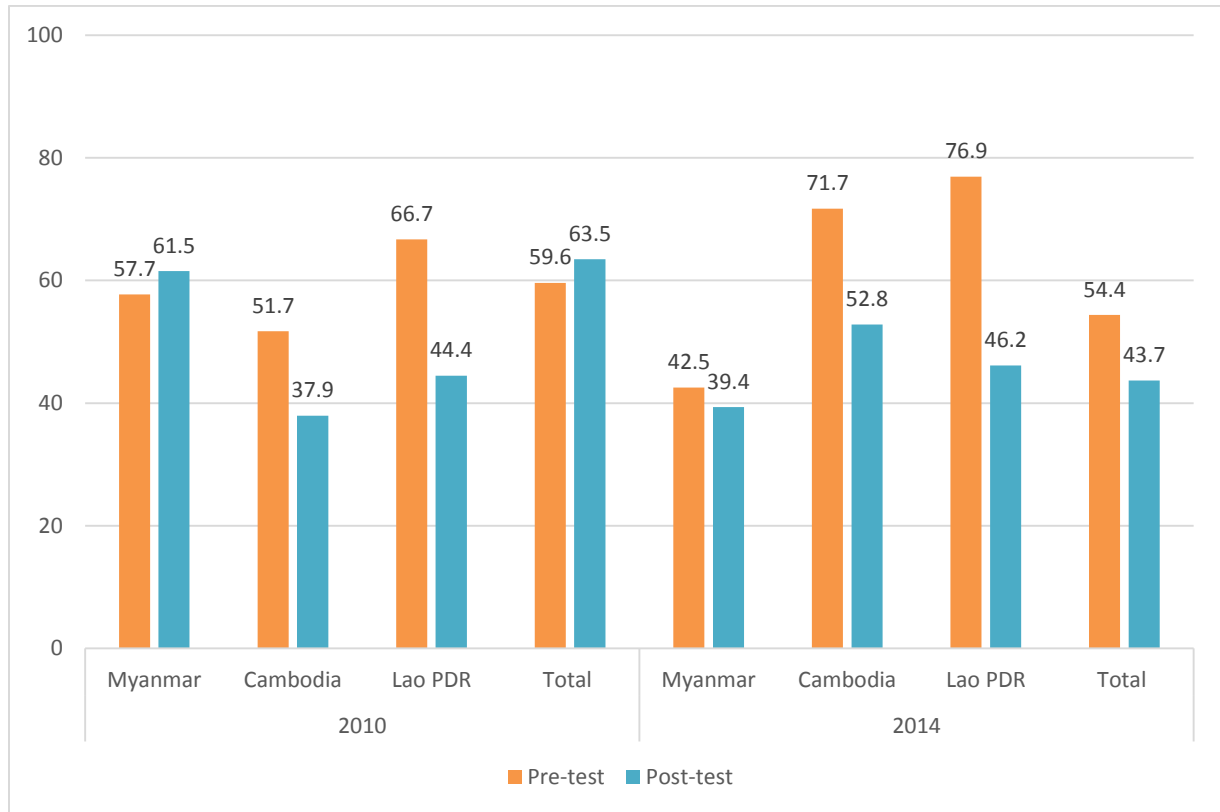
Figure 9.5: Reason for VCT by Nationality, Sex and Round

For the 2014 sample, the top three reasons for having VCT include requirement for employment, part of ANC service, and suspected self-risk for HIV (40%, 26% and 21% respectively). These were also the top three reasons for MW at the baseline, but the order was different (Figure 9.5). *It is noteworthy that 15% said they were forced to have an HIV test* (mostly male Burmese and Lao MW).

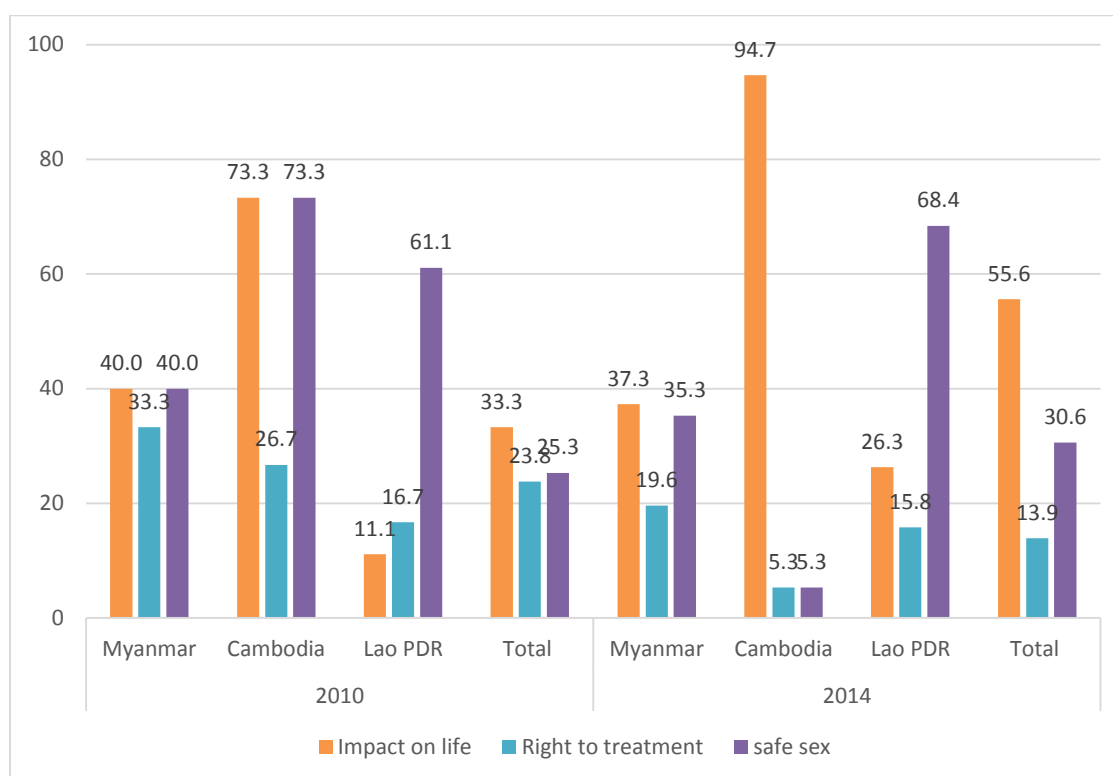
9.3 Counseling experience at the HIV testing service

MW who had HIV testing in the prior year were asked about the provision of counseling as part of the service, including pre-test and post-test counseling. The proportion of MW who reported receiving pre-test or post-test counseling during HIV blood testing actually decreased over rounds (from 60% to 54%, and 64% to 44% respectively) (Figure 9.6). However, these patterns are weighted by the experience of the MW from Myanmar who experienced significantly less pre-/post-test counseling over rounds, while Cambodian and Lao reported increased counseling experience. Decrease in counseling for the MW from Myanmar could reflect the increase in compulsory testing for employment or other reasons for this nationality.

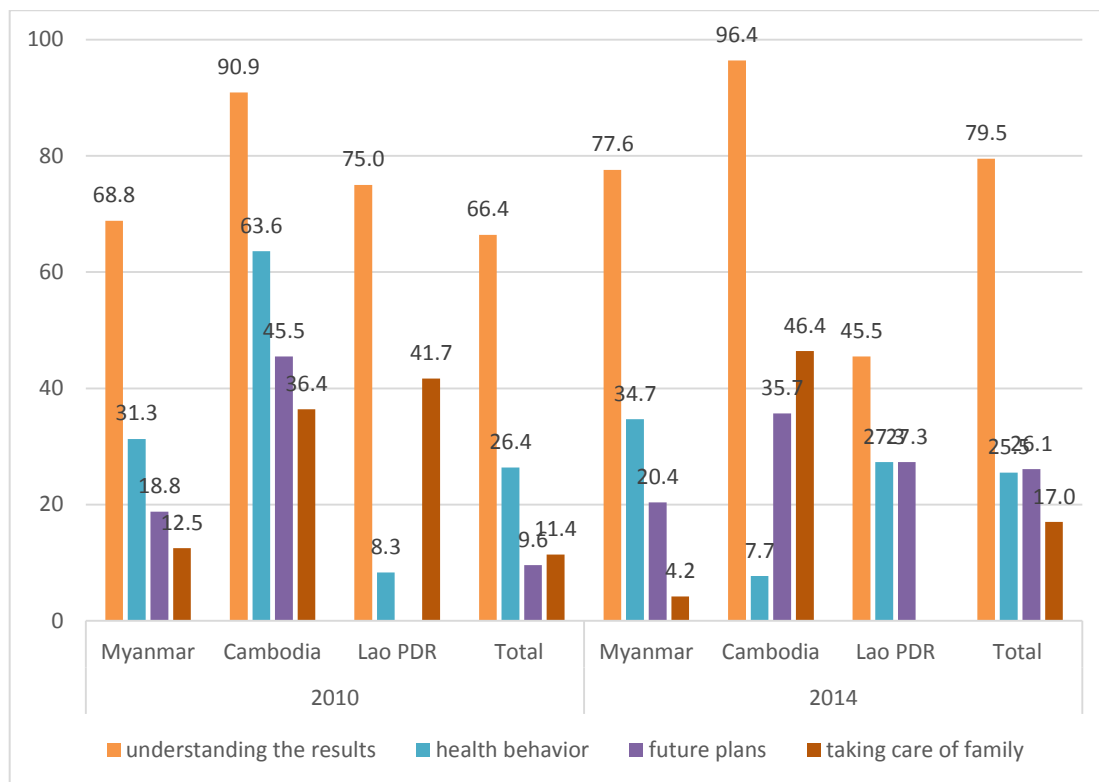
Figure 9.6: Percent Who Received Pre- or Post-Test Counseling During HIV-testing Service by Nationality and Round



The MW were asked about the content of the pre-test counseling at last VCT (Figure 9.7). Most common content was adverse impact of HIV/AIDS on one's life (reported by one-third of MW in the Baseline and over half in the Follow-up). The second most common topic was safe sex (reported by one-fourth and 30% of MW over rounds). The third most common topic was right to treatment (reported by one-fifth and 14% over rounds).

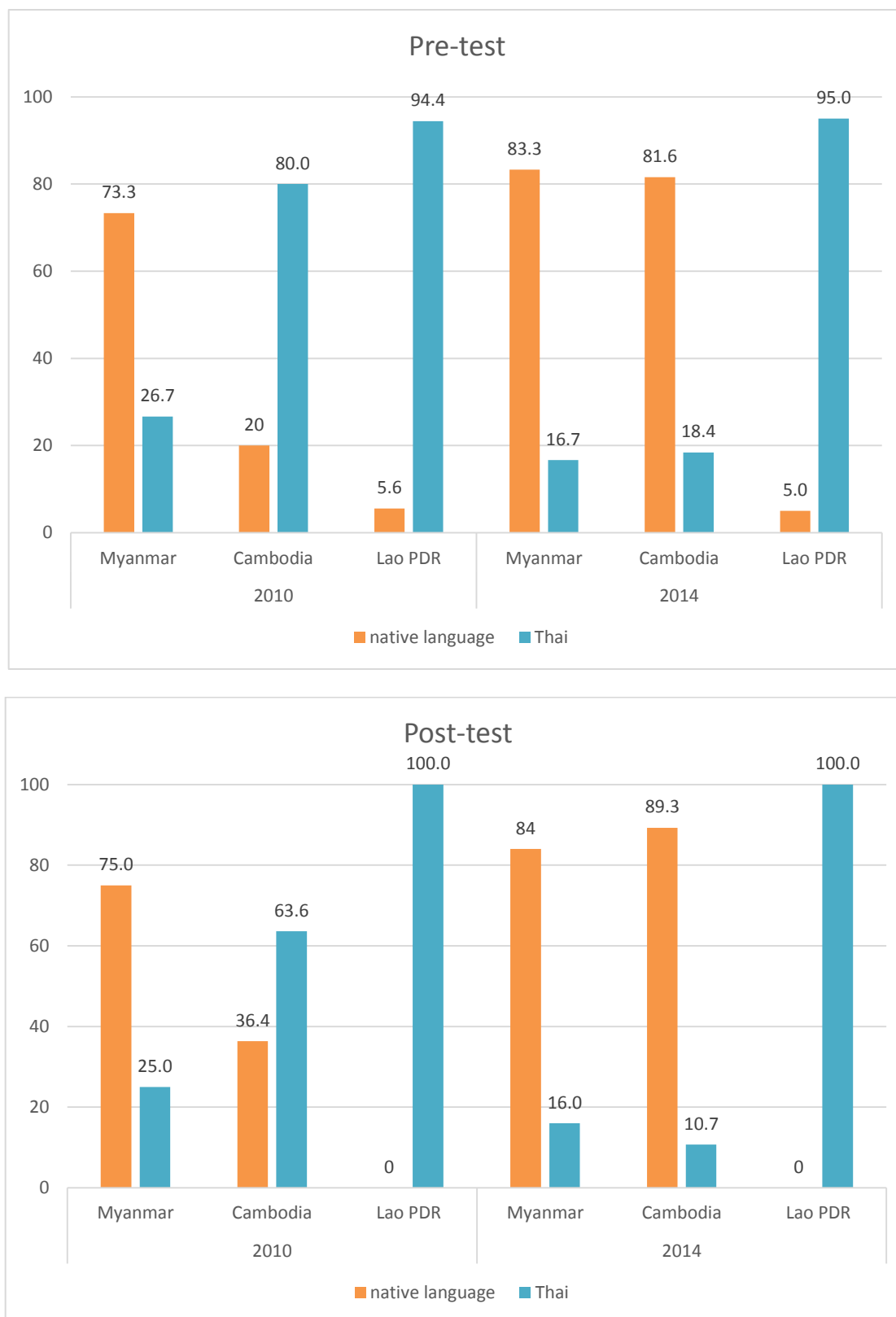
Figure 9.7: Content of Pre-test Counseling by Nationality and Round

MW were also asked about the content of the post-test counseling at last VCT (Figure 9.8). The most common topic in both survey rounds was understanding of the diagnosis (66% and 80% by round). About one-fourth in both rounds received counseling on health behavior and staying in good health. Ten percent and 26% by round received counseling on future aspirations, while 11% and 17% were counseled about looking after family members.

Figure 9.8: Content of Post-test Counseling by Nationality and Round

MW were asked what language was used for the pre- and post-test counseling session (Figure 9.9). Use of the native language of the MW from Myanmar and Cambodia increased distinctly over rounds for both pre- and post-test counseling, and this was most apparent for the Cambodian MW. Lao MW were invariably counseled in Thai in both rounds. Thus, by the Follow-up Survey, over 90% of all MW had counseling in either their native language or a language they were fluent in.

Figure 9.9: Language Used During the Counseling Session by Nationality and Round



9.4 Receiving the HIV blood-test results

MW who had HIV testing were asked if they received their test results and who accompanied them to hear the results (Figure 9.10). Only 85% of the MW in the Follow-up survey received their test results, and this is a decline from the 94% who reported receiving test results in the Baseline. *Again, this could reflect the increase in compulsory testing for the Burmese MW as a requirement for employment or other reason, and not part of a VCT service.* The average duration between giving a blood sample and receiving the test results was 9 days, and this was the same over rounds.

Figure 9.10: Percent Receiving Results of HIV Test by Nationality, Round and Accompanying Person



About one-third of the MW were alone when they received their test results. For those MW who had someone accompany them for the test results, the person was usually a spouse/partner, family member or close friend. Employers were rarely present to hear the test results and only among MW from Myanmar and Cambodia.

10

Family Planning

In general, the fertility rates of the home countries of the MW is higher than among the Thai population. Part of this is lack of knowledge, approval or access to contraception. This chapter presents results from the Baseline and Follow-up services on family planning, contraception, reproductive health (RH), child-bearing, and service outlets. The Project conducted activities to promote maternal and child health (MCH) for the female MW, many of whom worked in factories, by increasing awareness, favorable attitudes and improvements in RH through voluntary family planning.

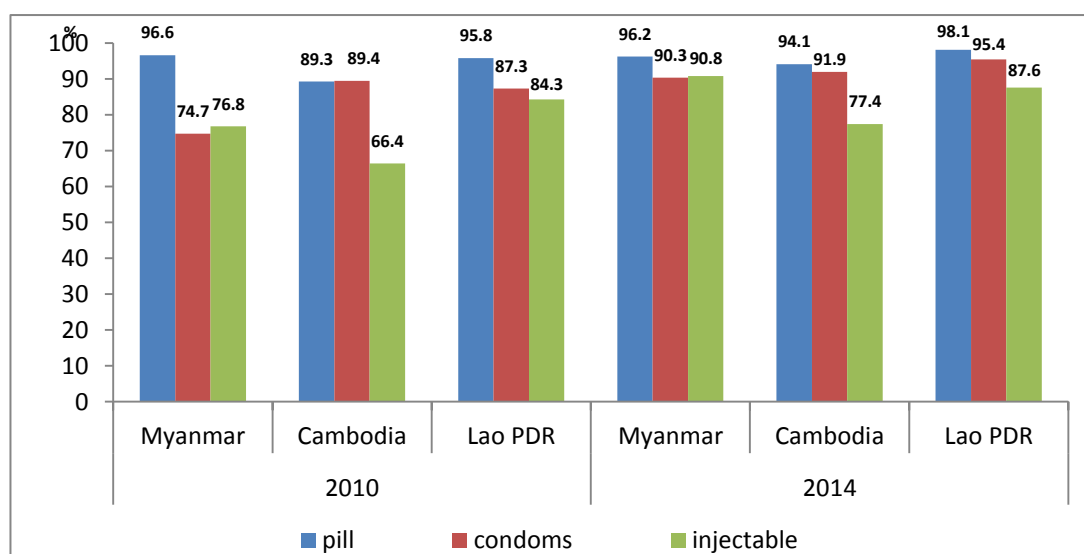
10.1 Contraception

MW who were currently or ever-married were asked about knowledge and use of modern contraception, including direct interviews with women age 15-49 and asking men about their female partners age 15-49.

10.1.1 Knowledge of modern contraception

Knowledge of the pill (oral contraceptive) was almost universal among the MW, for all groups and both rounds (see Table 1 in Appendix A and Figure 10.1). Knowledge of the condom (as contraceptive) and the injectable contraceptive was also high and increased over rounds (ranging from 77% to 91% in the 2014 round for the injectable). Knowledge of female sterilization increased from 68% to 91% over rounds. Knowledge of the IUD nearly doubled from 25% to 47% over rounds, while knowledge of the sub-dermal contraceptive implant increased from 37% to 46%.

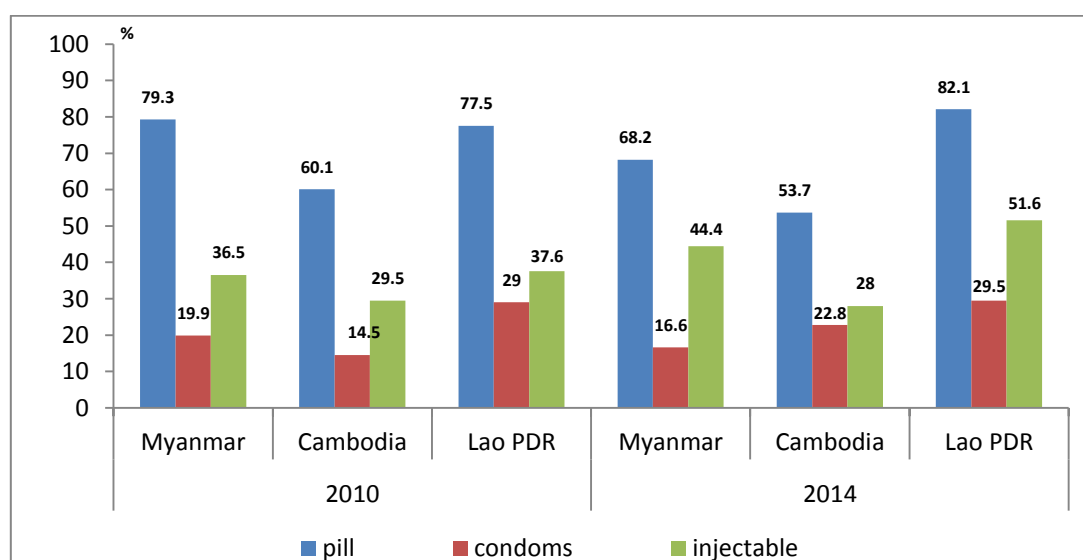
**Figure 10.1: Top 3 Methods of Modern Contraception Known
Nationality and Round**



10.1.2 Ever-use of contraception

Nearly all the MW had ever used some form of modern contraception, with the pill being the most common, though declined in ever-use prevalence from 77% in 2010 to 66% in 2014. Ever-use of the injectable was constant over rounds at about 40%. Ever-use of condoms for contraception was rather low but did increase from 15% to 20% over rounds. The pill was the dominate method for all three nationalities but the Lao were more varied in using condoms or the injectable than their Burmese or Cambodian counterparts, as over half of the Lao MW had used the injectable as of the Follow-up survey (Figure 10.2). Lao MW also had the largest proportion reporting female sterilization (24% in 2010 and 15% in 2014).

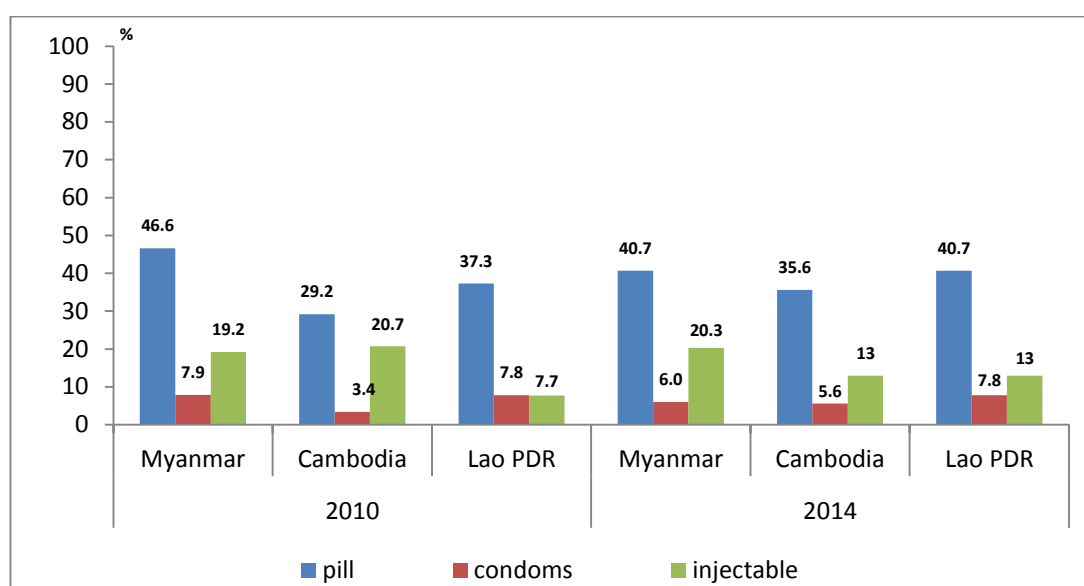
**Figure 10.2: Top 3 Methods of Contraception Ever Used by
Nationality and Round**



10.1.3 Method of contraception currently used

Overall, the proportion currently using the pill declined slightly over rounds from 42% to 40%, while use of the injectable declined from 21% to 18% over rounds. Use of condoms as a contraceptive was rather low at about 6% in the Follow-up survey. Use of the pill in 2014 was 36% for Cambodian MW and 41% each for MW from Myanmar and Lao PDR. Pill use declined significantly for the Burmese women but increased slightly for their Lao and Cambodian counterparts. Use of the injectable was constant for Burmese women (20%), but declined from 20% to 13% for Cambodian women and increased from 8% to 13% for Lao women over rounds. Use of the contraceptive implant was less than 3%.

Figure 10.3 Method of Contraception Currently Used (Top 3) by Nationality and Round



10.2 RH of female MW

10.2.1 Family formation and family size

Among MW couples in which the woman was 15 to 49 years old, half had a child in 2010, and 77% did so in 2014. Fertility of MW from Myanmar increased from 50% to 76% over rounds who reported having a child. For Cambodian and Lao MW, fully 79% and 83% reported having a child in the Follow-up survey. In 2010, the Lao MW had an average of 2.0 children compared to 2.1 for MW from Myanmar and 2.3 for Cambodian MW. The corresponding figures for 2014 are 1.9, 2.1 and 2.14 children, respectively.

Most of the respondents in 2010 said that the decision to have a child was a joint decision by the couple (92% for Burmese and 94% for Cambodian MW). As of 2014, the proportion declined a bit for Cambodians to below 90%, while over 90% of Burmese and Lao MW said the decision to have a child was joint. In 2010, 39% of MW said they would like to have 3 children, while 31% preferred only 2 (average of 2.8). But, by 2014, 40% said they would like to have 2 children, while 32% preferred to have 2 (average of 2.7). By 2014, desired family size was higher among the Cambodian MW (average of 2.9) compared to 2.6 for Burmese and 2.4 for Lao MW. The average age of the youngest child increased from 5.7 years in 2010 to 6.7 years in 2014. All three nationalities reported increased age of youngest child over rounds. Most the MW reported that their births were intentional and not the result of accidents, but it is noteworthy that as much as 15% of Lao MW in 2014 said their last child was not planned (40% among male Lao MW).

10.2.2 Birth delivery in Thailand and home country

Most of the MW women with a child under 5 years had delivered the youngest child in Thailand, especially the Burmese women (73% in 2010 and 71% in 2014). The proportion for Cambodian women was 49% and 50% by round. Overall, delivery in Thailand declined from 73% to 65% over rounds, possibly reflecting easier commuting between countries over time. Most of the deliveries in Thailand occurred at a government hospital, and this was true for all three nationalities over rounds. A minority of MW (e.g., Cambodian women) were delivered by a traditional birth attendant.

10.2.3 Complications of delivery in Thailand

Complications of delivery were reported to be low (never exceeding 8%) for all three groups over rounds. Complications were mild such as headache or minor vaginal bleeding, but the number of the sample is too small to conduct meaningful comparisons.

10.2.4 Antenatal care (ANC) in Thailand

Table 10.1 in Appendix A presents the proportion of MW women who received ANC in Thailand for their last pregnancy of a child under age five years. All three nationalities reported receiving ANC from a trained clinician (84% and 82% by round). As with delivery, most of the ANC for the MW occurred at a government hospital, and this remained constant over rounds and nationalities. But significant proportions also went to a health center for an ANC check-up as well. In 2010, fully 61% of the Lao MW said their husband accompanied them on some ANC visits compared to 33% of Cambodian women, and 28% of Burmese women. The

proportions reporting their husbands' accompanying them for ANC increased by 2014 to 81%, 66% and 66%, respectively.

10.2.5 Post-partum care in Thailand

Over half the MW in both 2010 and 2014 had post-partum care, with Cambodians reporting the highest level (79%) followed by 64% of Lao. The women from Myanmar had the lowest and declining levels of postpartum care in Thailand with 56% in 2010 and 49% in 2014. As with delivery and ANC, the government hospital was the most common source of the post-partum care for all groups. As with ANC, more Lao husbands accompanied their wife for the post-partum care visit (82% in both rounds) with lower proportions for Cambodian MW (47% to 64%) and lowest for those from Myanmar (33% to 26%).

10.2.6 Access to child care services

Overall, if the MW has a child under age five years who was ill or injured, most would take the child first to a health center or hospital (73% and 82% by round). For (85%) of Lao MW, both parents took the child for care compared to 60% for Cambodians.

11

Access to Health Services

Access to health services is a basic human right that also extends to foreign MW in Thailand, regardless of their legal status. MW often live in dense, low-income communities with an environment that is not always conducive to good health and hygiene. Also, the MW work in jobs that are prone to injury. Most MW still lack health insurance. The barriers to accessing health services include lack of funds, lack of an alien ID card or work permit, illegally working in Thailand, and socio-cultural issues. But aside from these personal factors, there are also structural and procedural issues of the health system in Thailand which may discourage even those MW with proper ID and health insurance to choose not to go to government service outlets. This chapter presents results from the Baseline and Follow-up surveys on how the MW access health services when needed, the cause for seeking care, type of care facility, experience at the health care outlet during the last visit, client satisfaction, convenience of health services, differences between public and private outlets, and referral for counseling, special care for STI, VCT or other health services. A final section examines the issue of health insurance schemes which the MW are eligible for.

11.1 Illness, injury and health-seeking behavior

The proportion of the samples that had an illness or injury in the 12 months prior to the interview which required clinical care declined over rounds from 91% to 85%. (Figure 11.1) The proportions are higher for Cambodian and Lao MW. It is noteworthy that more female MW required clinical care than males (88% versus 80% in 2014).

Figure 11.1: Percent of MW Who Had an Illness/Injury Requiring Clinical Care in the Past 12 Months by Nationality, Sex and Round

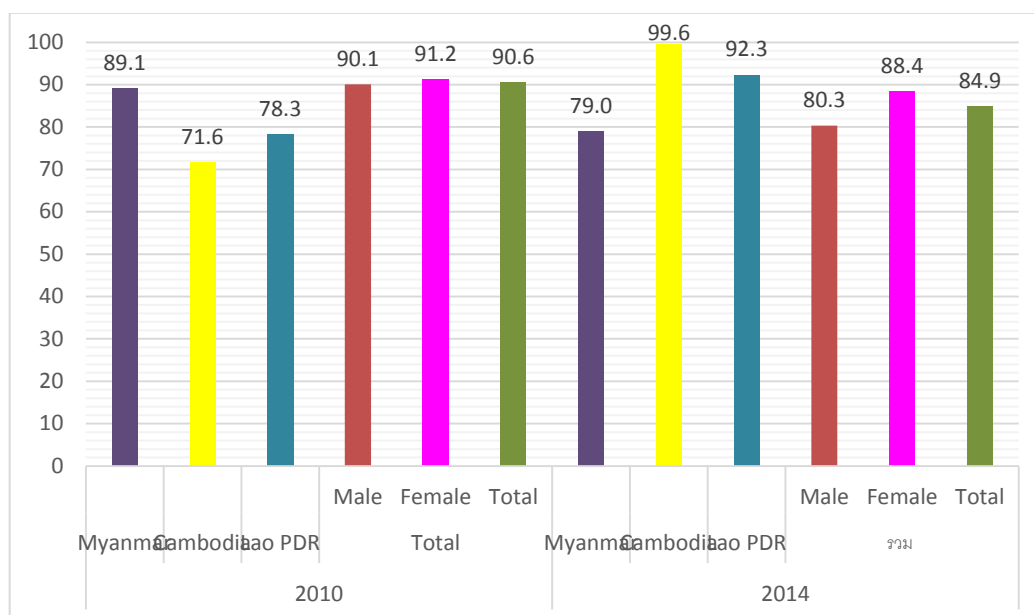
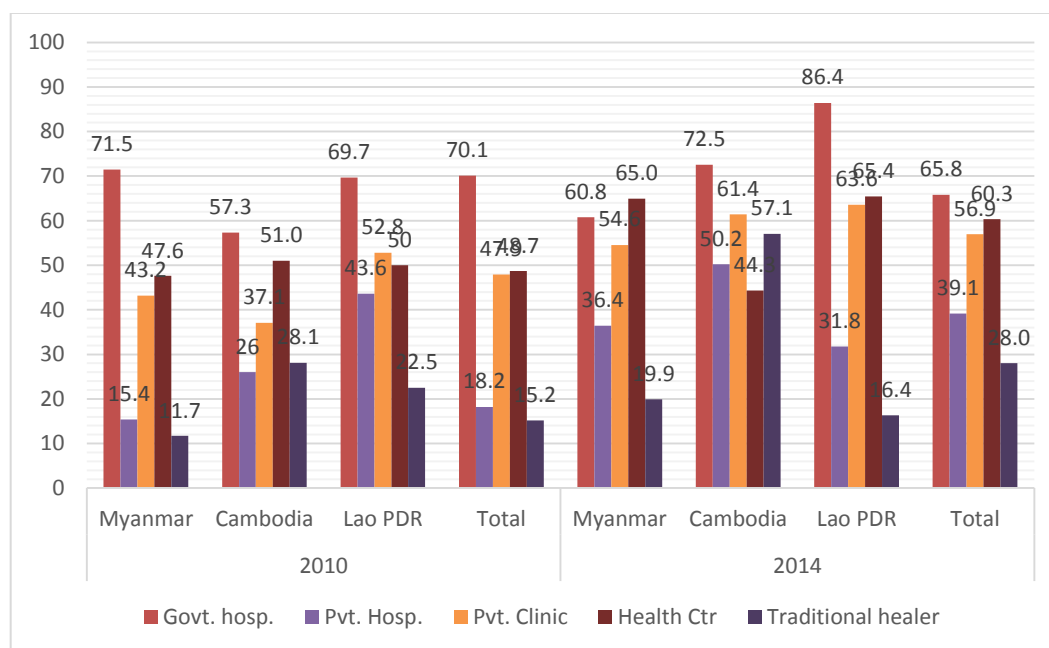


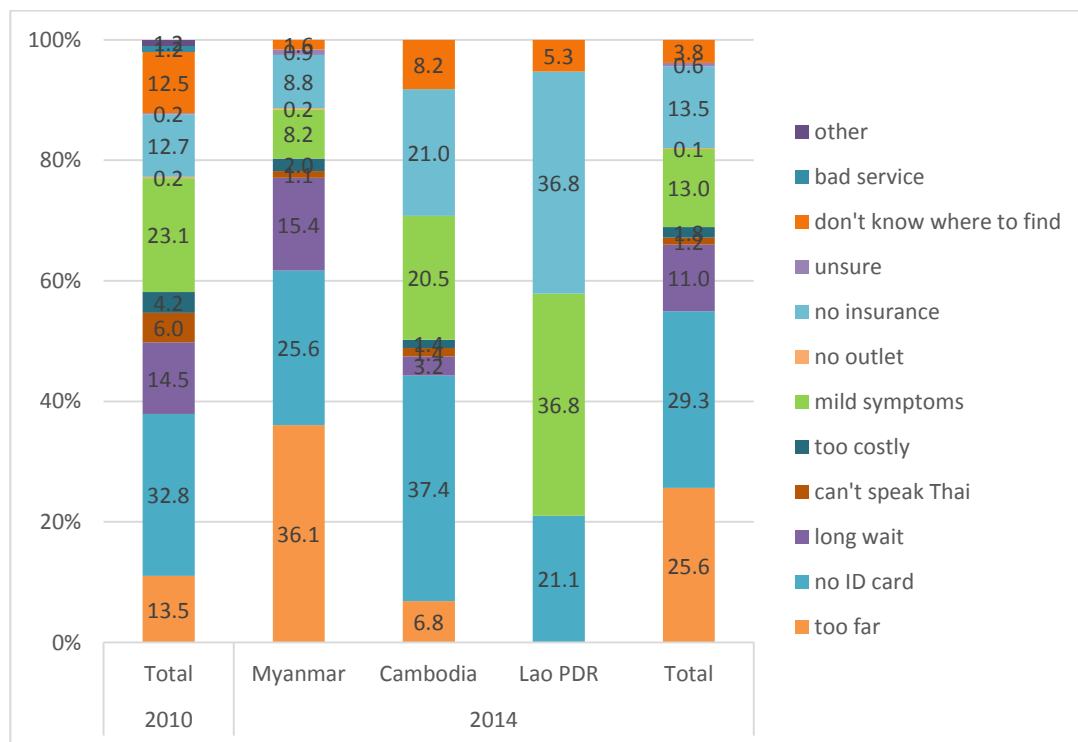
Figure 11.2: Decision to Seek Health Care by Type of Outlet by Nationality and Round



MW were asked about their decision to seek clinical care and, overall, the patterns did not change greatly over rounds (Figure 11.2). That is, most (66%) in 2014 said they sought care at a public hospital, followed by health center and private clinic (60% and 57% respectively). It is noteworthy that as many as 28% in the Follow-up Survey still preferred to seek care from a traditional healer, and that represents an increase from 15% in the Baseline.

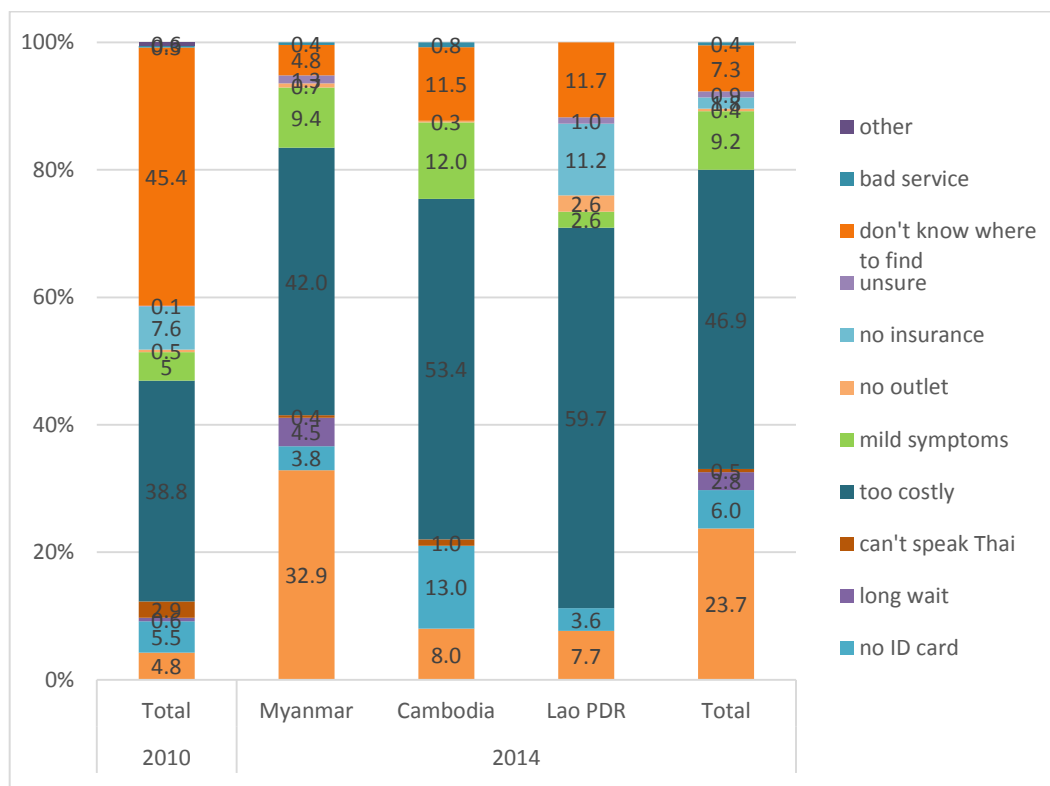
By nationality, the Burmese and Lao MW had similar care-seeking patterns. MW from Myanmar elected to go to a health center (65%) or public hospital (61%), whereas 86% of Lao chose a government hospital and 65% went to a health center. A private clinic was the third choice for these two groups of MW at 55% and 64% respectively). While Cambodian MW also chose the government hospital as a first option, there second choice was a private clinic in the 2014 round (72% and 61% respectively). It is also noteworthy that 57% of Cambodian MW chose a traditional healer for the last episode of illness/injury in the 2014 round.

Figure 11.3: Reasons for Not Seeking Care at a Government Hospital by Nationality and Round



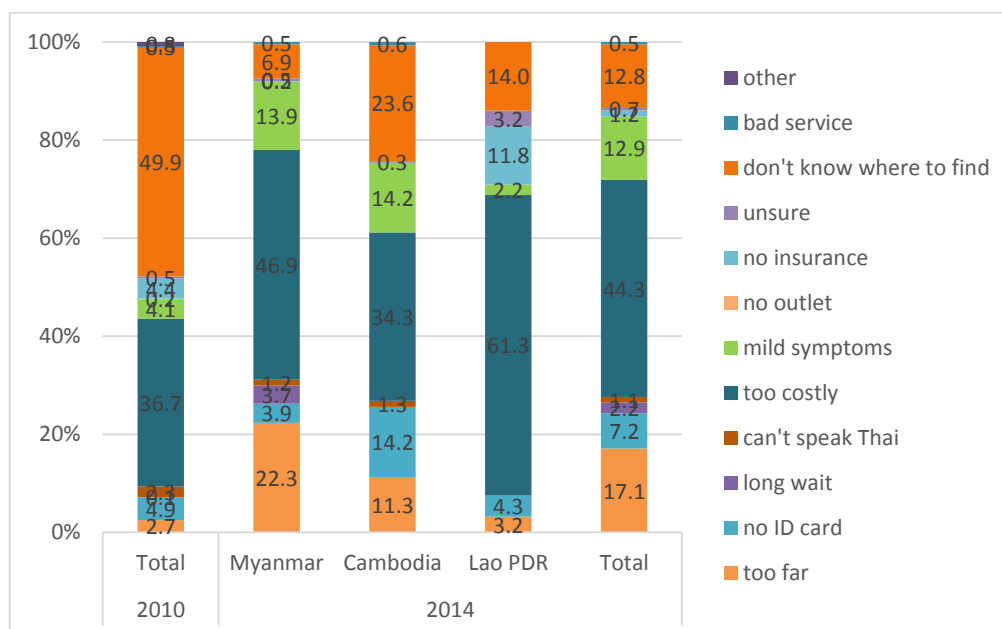
The top three reasons for not seeking care at a government hospital in the Baseline and Follow-up is lack of an ID or health card, followed by lack of severe symptoms and remote location (Figure 11.3). Lack of Thai language ability was an insignificant deterrent to seeking health care at a public hospital.

Figure 11.4: Reasons for Not Seeking Health Care at a Private Hospital by Nationality and Round



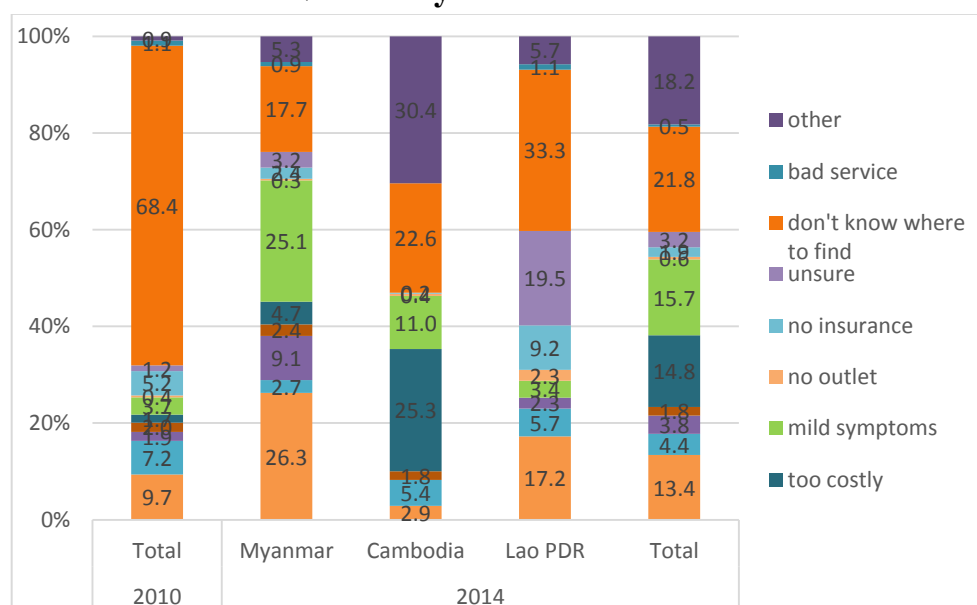
In the baseline, under half the MW were not aware of the availability of a private hospital to go to or did not have the funds to pay for care. By the follow-up in 2014, cost of care was the dominant reason for not seeking care, as 47% cited this factor, and was the same for MW from Myanmar, Cambodia and Lao PDR (42%, 53%, and 60%, respectively). In the Follow-up, one-fourth of MW said there was no private hospital in the vicinity, but this was mostly an issue for MW from Myanmar (33%).

Figure 11.5: Reason for Not Seeking Health Care at a Private Clinic by Nationality and Round



The level and pattern for not seeking care at a private clinic is much the same as for a private hospital (Figure 11.5). That is, in the Baseline half the MW said they were not aware of a private clinic in their neighborhood while, in the Follow-up, 44% cited cost of care as a barrier; by nationality 47%, 34% and 61% respectively for Myanmar, Cambodian and Lao MW.

Figure 11.6: Reason for Not Seeking Care at a Health Center by Nationality and Round

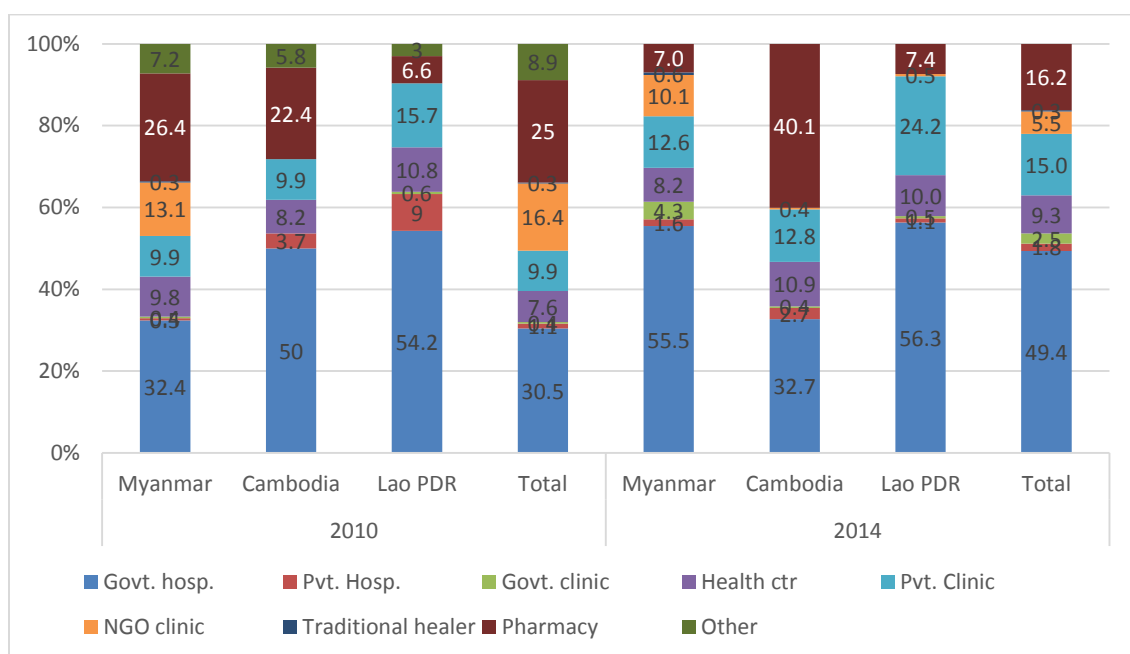


While in the Baseline the predominant reason for not visiting a health center was lack of knowledge of such an outlet (68%), the response was more varied in the Follow-up (Figure 11.6). Lack of awareness was still a factor for 18%, 23% and 33% of Burmese, Cambodian and Lao MW, but lack of severe symptoms and cost of care were also important factors in 2014.

11.2 Experience receiving care for the last episode of illness/injury

MW were asked about their last experience at a health care outlet in the past year (Figure 11.7). The government hospital continues to be the most common point of contact overall (for 3% and 49% by round), but there is variation by nationality. In 2014, fully 40% of Cambodian MW self-treated at a pharmacy for the last illness, nearly double the proportion in the Baseline. Fully 56% of both Lao and Burmese MW visited a government hospital for the last episode of illness in the Follow-up survey, and private clinics were the second most frequented outlet for last episode (24% and 13% respectively). Only one-third of Cambodian MW reported visiting a government hospital in the Follow-up survey.

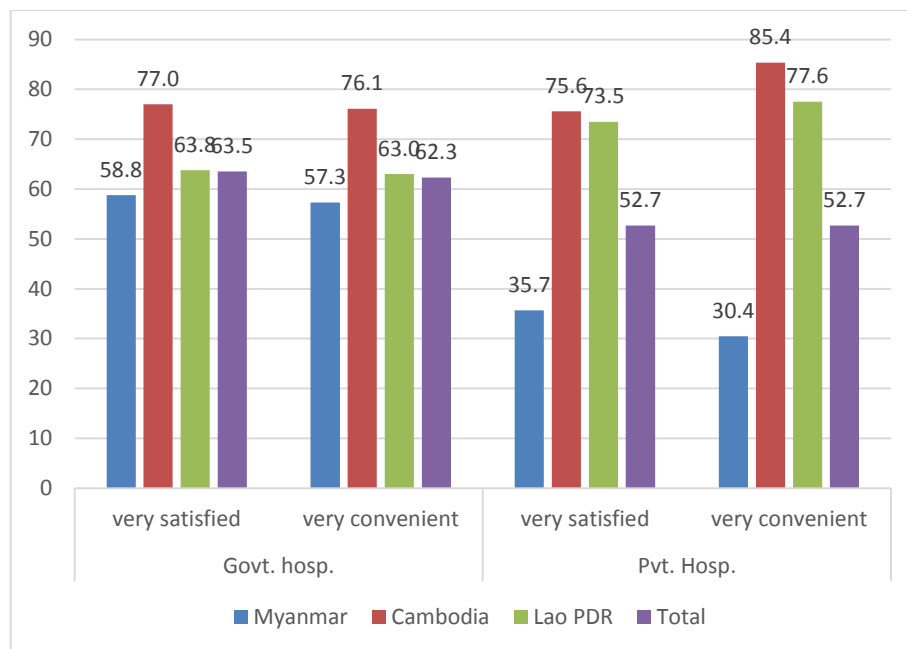
Figure 11.7: Type of Health Care Outlet Visited at Last Episode of Illness/injury by Nationality and Round



MW were asked their level of satisfaction with the service at last illness by government or private outlet (11.8). In 2014, 64% of MW who attended a public facility were “very satisfied” with the service they received (59%, 77% and 64% by Burmese, Cambodian and Lao MW, respectively). The remained were “rather satisfied” with

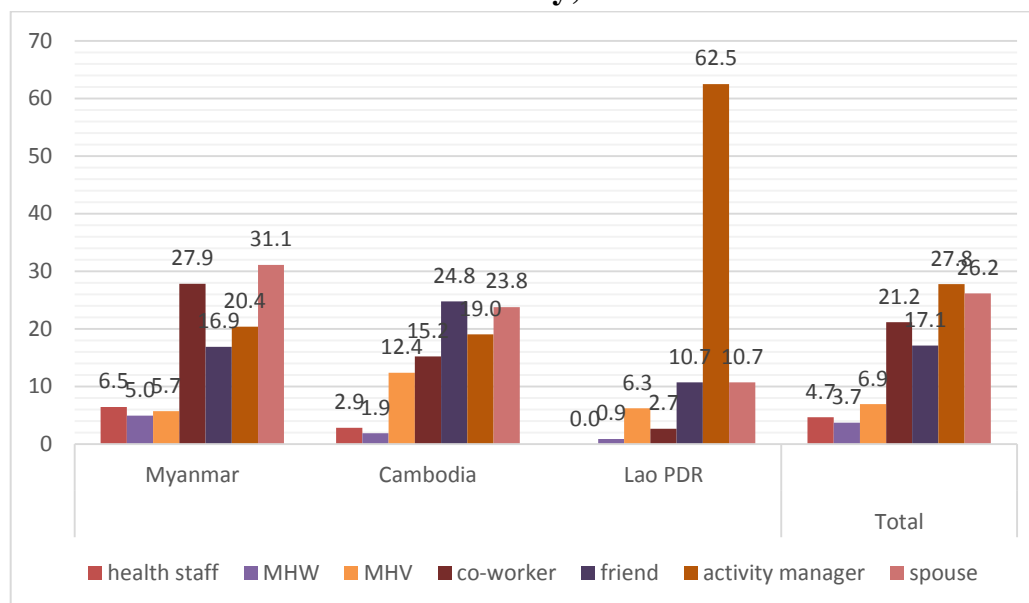
the government health service. Less than ten percent of each nationality were “not satisfied” with the service. As for convenience, in 2014 62% said that the public health service was “very convenient” (57%, 76% and 63% by Burmese, Cambodian and Lao MW, respectively), and 30% said the service was “rather convenient”. For those whose last illness/injury was cared for by a private outlet in the year prior to the 2014 survey, 53% reported being “very satisfied” with the care they received and the same proportion said the services was “very convenient.” However, it is noteworthy that the MW from Myanmar had less than half the satisfaction and convenience of service at the private outlet compared to their Cambodian and Lao counterparts.

Figure 11.8: Satisfaction of Service by Public and Private Outlet and Nationality, 2014



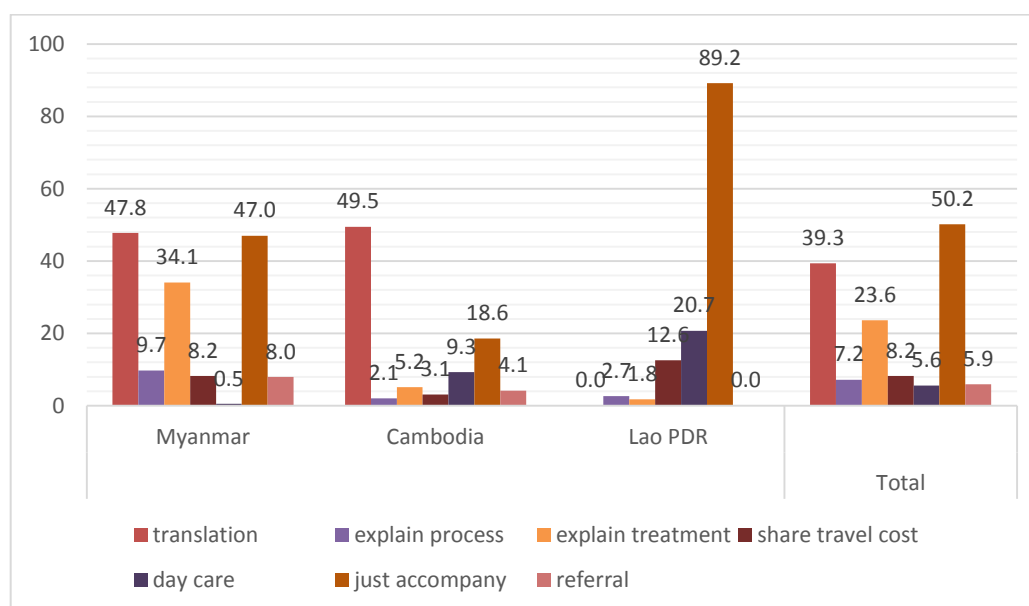
Among those MW who sought health care in the year prior to the 2014 interview, two-thirds said that they received assistance in seeking care for the last episode from the activity manager, their spouse or a co-worker (28%, 26%, and 21% respectively) (Figure 11.9). The MHW assisted in 17% of the cases. For Lao MW, the activity manager was the most important facilitator in seeking care as 62% received assistance from that personnel. Otherwise, the patterns by nationality are not distinctly different.

Figure 11.9: Type of Person Who Assisted in Accessing Health Care by Nationality, 2014



MW were asked what type of assistance they received in seeking health care for the last episode of illness in the 2014 interview (Figure 11.10). Common types of assistance include just accompanying the MW, providing referral, or explaining the process of obtaining care. Helping with language translation was an important source of assistance for just under half of the MW from Myanmar and Cambodia. Lao MW needed the least assistance and mostly just had a friend or relative accompany them (89%).

Figure 11.10: Type of Assistance Received in Seeking Health Care by Nationality, 2014



11.3 Special kinds of health care received

MW from Myanmar

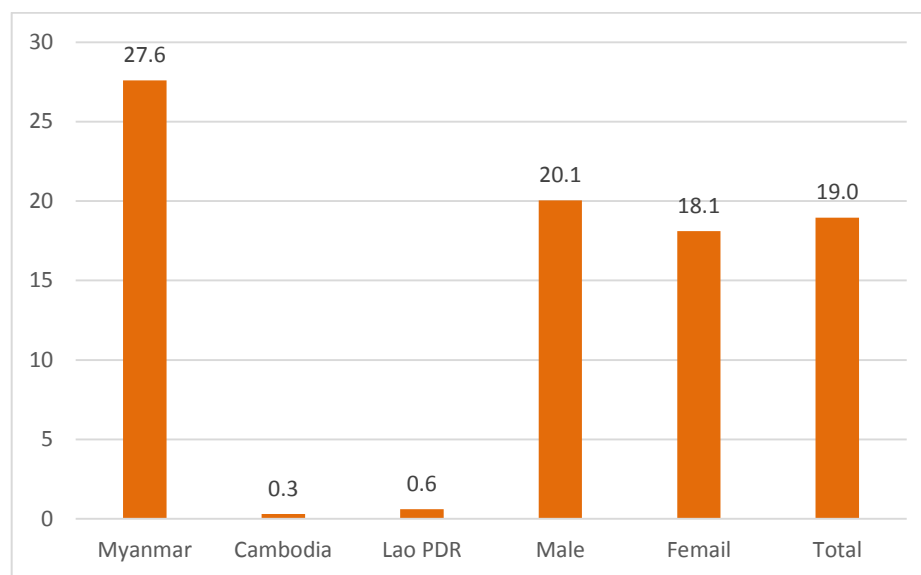
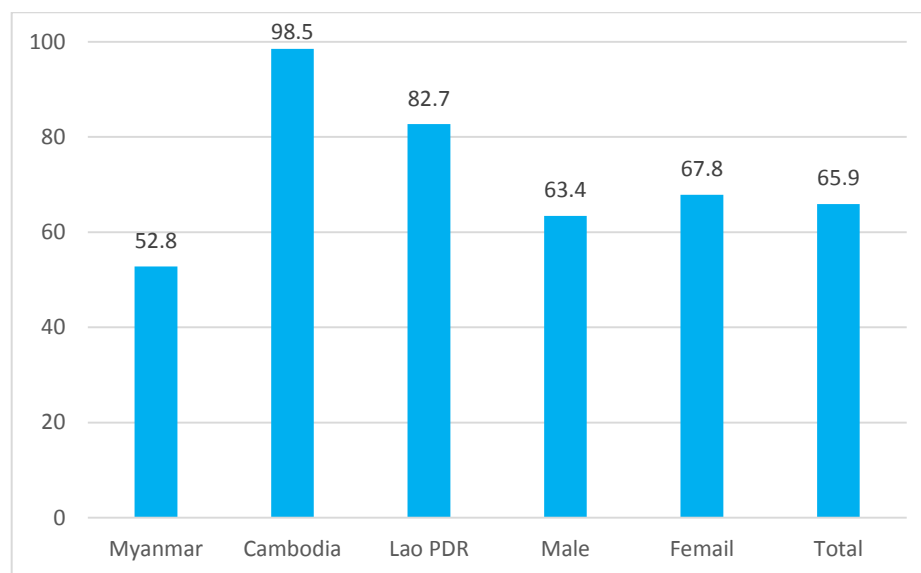
In the 2014 survey, over one-fourth (28%) of MW from Myanmar reported having some kind of services related to STI symptoms (e.g., diagnosis, treatment, counseling or referral) in the previous 12 months and, of these, 73% received one to three episodes of care. Most (92%) of the care was at an NGO clinic (e.g., WVFT, RTF, MAP Foundation). Two-thirds of the care providers were MHW and nearly all said that the medium of communication was Burmese. For VCT, one-tenth of the MW had at least on VCT visit in the prior 12 months and most had one to three visits. As with STI, 91% of the visits were at one of the Project NGO clinics named above, and 82% were seen by a MHW, and all communication was in Burmese. Only one percent of MW said they received legal or rights assistance in the prior 12 months. Over half the MW from Myanmar had received condoms from distribution campaigns or projects, three-fourths of the condoms were free. Most of the free distribution was from one or more of the above three Project NGOs. The condom distributors were either MHW (65%) or MHV (34%).

MW from Cambodia

Only one percent or less of Cambodian MW received STI, VCT or legal/rights assistance in the 12 months prior to the 2014 interview. However, nearly all had received condom distribution, mostly one to three times during the year. Nearly all of this activity was by the Project NGOs (RTF and FAR), and all of the communication was in Khmer.

MW from Lao PDR

Only one percent or less of Lao MW received STI, VCT or legal/rights assistance in the 12 months prior to the 2014 interview. Over 80% of the MW received free condom distribution, mostly one to three times per year. Nearly all distribution was conduct by or through a Project NGO (AIDS Network Foundation and RTF). About 40% of the Lao obtained resupply by themselves from dispensers.

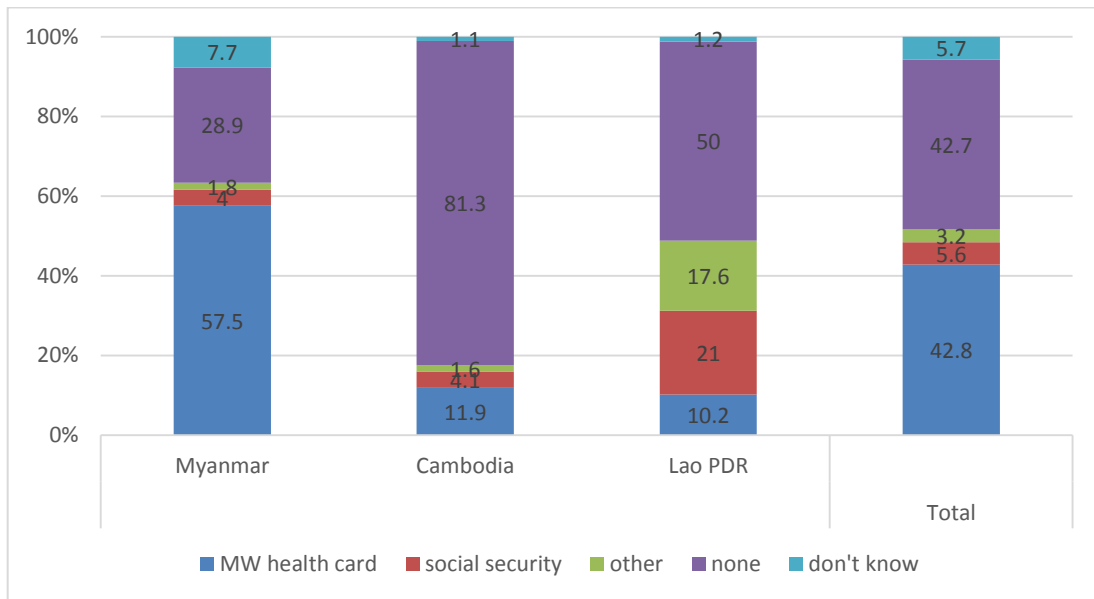
Figure 11.11: Received STI Case Management by Nationality, 2014**Figure 11.12: Received Condom Distribution by Nationality, 2014**

11.4 Health insurance coverage

MW in Thailand can obtain subsidized health insurance through special health programs for MW and through the Social Security System. Others, of course, can buy insurance in the open market. Having insurance greatly increases access to affordable health care, but coverage is uneven and below target.

Overall, half the MW in the 2014 Follow-up survey said they had government-subsidized insurance (43% with health insurance, 6% with Social Security). But there were important differences by nationality. While over 60% of Burmese MW had either health insurance or social security, over 80% of Cambodian MW and 50% of Lao MW had no insurance or did not know if they were covered.

Figure 11.13: Health Insurance Coverage by Nationality, 2014



12

Results of the Qualitative Evaluation

12.1 Structure, mechanisms and system of implementation

12.1.1 Management

RTF is the PR for the PHAMIT 2 Project, with eight SR: WVFT, FAR, Pattanrak Foundation, Stella Maris Seafarers Center, AIDS Network Development Foundation, MAP Foundation, the Social Development Foundation and the Bureau of Health Administration (BHA) of the MOPH. Ten PCMO participated as pilot sites: Chonburi, Rayong, Samut Sakorn, Samut Prakan, Tak, Chiang Mai, Pattani, Ranong, Songkhla, and Phuket (which later withdrew from the Project). In PHAMIT 1, there was an agreement for support with the MOPH as the SR, with the BHA overseeing management of public health activities of the Project partners. There was a rather close collaborative relationship among the partners in PHAMIT 1. However, in PHAMIT 2, there were changes in the management of some of the responsible implementing agencies, and within the BHA itself which made it difficult for it to honor its mandate for overall health administration of the Project. To accommodate this new environment, the managers of PHAMIT 2 decided to shift management authority to the PCMO in ten provinces, backed up by signed agreements with the PR, and accompanying budget. With these funds, the PCMO were expected to implement training of health staff to provide client-friendly services for MW, deploy mobile clinics to migrant communities for HIV VCT and STI screening, and development of strategic health plans for MW. Under the umbrella CHAMPION Project, RTF still had responsibility to provide technical support in the area of gender and sexuality for Project partners covering all target groups. In addition, under PHAMIT, FAR was responsible for training in conceptual thinking about sex and campaigns to improve the legal environment for MW.

12.2 Project advocacy mechanisms

Joint Strategic Management Committee (JSMC)

The JSMC was first established under PHAMIT 1 and met quarterly, and was designed to be a mechanism of communication among the Project partners for planning, strategic thinking, and trouble-shooting. The management board of PHAMIT 1 comprised managers from each of the implementing partners and the BHA. For PHAMIT 2, the board was expanded to include field managers but lacked a MOPH counterpart. The change in management structure over time had benefits and drawbacks. In PHAMIT, the board members were all senior management with broad views of the program. While PHAMIT 2 brought in the field perspective, the field managers did not have the same broad vision as the senior managers. Thus there was more focus on reporting and trouble-shooting rather than strategic adjustments.

12.2.1 Provincial Coordinating Mechanism (PCM)

During the SSF Round of the GFATM, PCM were established to formalize provincial coordination of AIDS projects and provide strategic guidance and alignment. The focus of the program were the four vulnerable populations of MSM, FSW, PWID and MW. In addition children affected by AIDS were an ancillary target group. The CHAMPION Program was under the management of the NAMc of the DDC of the MOPH, with budget to support the PCM through the PCMO, as the secretariat. This evaluation found that the role and effectiveness of the PCM regarding projects for MW varied from province to province, depending on the strength and interest of key staff and the PCMO. Advocacy for the various target populations varied as well. There was considerable overlap in membership of the various coordinating mechanisms, including program, Project and provincial committees. Efforts by the PCM to consolidate and streamline some of this management may have reduced duplication but also may have limited the voice of the target populations. In other cases, the PCM became so big as to lose focus and become unmanageable in some respects.

12.3 The mechanism of PHAMIT MHW and MHV

Both PHAMIT 1 and 2 promoted the role of the MHW and MHV as a mechanism to improve access to information, HIV prevention, and primary health care for MW. Bilingual MW were recruited and trained to conduct outreach and support for related services, including serving as interpreters between migrant client and Thai health provider. This strategy has received recognition and support from both provincial and national sources. PHAMIT's NGO partners employed the MHW and provided benefits in line with NGO policies, and basically functioned in the same capacity despite having

different classifications by the different NGOs (e.g. Field Officer Migrant, Front Line Social Network).

The role of the MHW was to inform MW about health issues, refer needy migrants for clinical services at government outlets, distribute condoms and lubricant, provide basic counseling, and assist with basic social services. MHW also facilitated community outreach activities and links with mobile clinic services. Although the MHW were mostly nationals of the MW country, in some cases for Lao MW, Thais were recruited as the MHW because of the commonality of Thai and Lao languages. PHAMIT enabled the hiring of MHW to be placed at hospitals in the target area and became an integral part of the service program for MW. Indeed, despite the conclusion of external support, many hospitals allocated funds to continue to employ the MHW because of their critical importance to providing a client-friendly service.

PHAMIT also promoted recruitment of MHV from the MW community to serve as peer educators and links with the migrant community or worksite. The MHV were not paid salaries but were reimbursed for travel expenses when they facilitated activities. The MHV helped recruit migrants to join training programs, distribute condoms and educational media, and screen persons for risk in preparation for outreach by field staff and the MHW. The MHV linked with local health center staff and Thai VHV to publicize campaigns on diarrheal disease outbreaks, identify suspected cases of hemorrhagic fever, and distribute material to suppress mosquito breeding. Based on the favorable experience from PHAMIT, PCMO are recruiting and training their own cadre of MHV to augment the VHV in Thai communities to ensure coverage of areas with large populations of foreign migrants.

A pressing problem is how to continue to employ the non-Thai MHW since there is no clear policy on this employment category in the government health personnel system. Also, the relatively low salary of the MHW leads to high turnover. There is limited budget for in-service training and capacity building of the MHW and MHV. Also, there is high turnover of the MHV due to frequent migration for new employment, requiring new recruitment and training each year. Field staff have observed that it is increasingly difficult to recruit suitable candidates for the MHW position who have the background and dedication to suit the position. Also, skills in developing rapport with the employers of the MW (in order to gain access to the workforce) is not an innate ability and needs additional training. Most of the candidates for MW do not have an education or background in public health or profound understanding of the range of contexts which the MW face in their daily lives. *Ultimately, if the MHW can find work that pays more than the MHW salary, they will leave.*

12.4 Outreach

12.4.1 Target population of the Project

PHAMIT 1 focused on 18 coastal provinces and MW from Myanmar and Cambodia working in the fisheries industry and seafood processing. PHAMIT 2 expanded coverage to 14 additional provinces and included Lao MW as part of the target population. The MW occupations now included fisheries, factory work, construction and agro-industry. Among groups, those working in agro-industry and construction were rather hard to reach with Project services. Also, the younger cohorts of MW had lower participation rates in Project activities. In addition, some MW married at a young age (e.g., 13 or 14 years) – and thus vulnerable for RH problems -- but were technically not part of the Project which defined the target population as persons age 15-49. MW working in the entertainment industry and FSW were target population in PHAMIT 1 but not in PHAMIT 2 because CHAMPION no longer gave priority to this group.

12.4.2 Outreach for behavior change

The outreach conducted by the SR NGOs consisted of awareness raising for increased prevention behavior and distribution of condoms and lubricant, and referral for VCT and STI case management. The content of the outreach education included the package of HIV/AIDS knowledge, routes of transmission, contact with PLHIV, condom use and managing HIV infection. There was also a module on STI, symptoms, prevention and case management. There was additional information on RH, MCH, family planning and contraception, but this was less emphasized in PHAMIT 2 compared to PHAMIT 1. By contrast, there was more emphasis on gender and sexuality in PHAMIT 2.

Implementation was generally similar across provinces, with the use of MHW and MHV as key liaisons for the outreach. PHAMIT 2 produced more education media and in more languages, especially Lao. Information resource centers and drop-in centers (DiC) were set up in or near the migrant communities as a meeting place for MW to exchange information, receive services, relax and socialize. The DiC differed by location to suit the local context. Some DiC were fully equipped with A-V equipment and a wide range of educational media, counseling room and, in some cases a Burmese physician or clinician. Other sites were less well-equipped and had low utilization, calling into question the cost-effectiveness of the DiC and the optimal level of equipping and staff.

The Project organized free condom distribution for MW through a variety of channels such as small group education sessions, outreach staff, MHW, peer educators, condom boxes at the DiC, campaigns, and condom dispensers at worksites, and other convenient access locations in the community.

Project staff said that they always had adequate supply of educational print media, but that some of the Lao versions could not be used because of errors in grammar and idiom.

- **Condoms**

Staff said that supplies of condoms were adequate and improved in quality and features over time (flavor, color). But some MHW said the condoms were not always appropriate for some MW, and there was a need for more supplies of lubricant. Condom distribution achieved the Project targets. Staff and MHW said they observed indications of improved prevention behavior among the MW, and female MW seemed more confident in discussing issues related to sex and condoms, and some even came for resupply without embarrassment. However, use of condoms for preventing pregnancy among married couples was still low. Some staff observed that the dense living conditions of the MW, with some couples sharing a large room with only a curtain for privacy, might deter some to use condoms because of the noise in open the packet, or leaving wrappers in the shared waste receptacle.

- **Family planning**

In some locations, MW knowledge about RH was still limited, and PHAMIT 2 did not emphasize RH content as much as PHAMIT 1. Thus, some of these locations reported issues of unwanted pregnancy and abortion. SRs provided information on contraception and were able to receive supplies of the oral contraceptive from the PCMO and government hospitals for resupply to MW who had been prescribed the pill. Some MW women preferred the injectable since it is simpler, and usually went to private clinics for this service.

12.5 Capacity building

12.5.1 Field staff and MHW

Field personnel received the standard Project training (5-day curriculum) once a year which included content on prevention and control of HIV/AIDS and STI, client-friendly services at health outlets, RH, family planning, counseling, public speaking, community preparation, etc. Some SR provided on-the-job training and mentoring through monthly and quarterly meetings, activity planning exercises and budgeting, situation assessments, up-dates on labor laws, social security benefits, registrations of MW, meetings with staff of other agencies on gender issues, counseling, health

insurance, inter-personal communication skills, and distribution of handbooks and protocols as references.

Field staff and MHW felt that they had adequate training and had a good command of the core content, but some felt the need for more regular refresher training especially in the area of skills in communicating with the community and organizing participatory learning activities, and stimulating discussion, Q&A, and trouble-shooting.

The MHV and peer educators received capacity building from the Project field staff and MHW. However, some sites did not implement formal training for the MHV and, instead, simply gave orientation at meetings or periodic group discussions to clarify roles and responsibilities, and deliver the basic package of HIV/STI/VCT knowledge. Some of the peer educators felt that they still did not have adequate knowledge or skill to inform and advise others in certain areas, such as STI. Most of their function was to invite and encourage MW to participate in Project activities, and to explain the process of screening for STI and HIV, and distribute educational media and condoms in their neighborhood. They also informed Project staff when they learned of someone who was ill or injured and needed clinical care.

12.5.2 Health service providers

PHAMIT emphasized building the capacity of the health care providers (especially government staff) to provide client-friendly services to MW in the area of STI and VCT. The PR and SRs received support from the MOPH since its agencies were responsible for client-friendly services under the umbrella CHAMPION Program. In PHAMIT 1, the Department of Health Promotion was the PHAMIT counterpart in the MOPH for this activity. In PHAMIT 2 the locus of coordination and responsibility shifted to the Bureau of Health Administration (BHA). However, due to some delays in working out the PHAMIT agreements, the MOPH shifted authority for this to BATS and the PCMO in target provinces. Field staff were not always clear which branch of the MOPH was doing the staff training to improve client-friendly services. But, overall, the field staff were satisfied with the participation of the MOPH staff in the Project.

Staff of a provincial hospital who had participated in PHAMIT 1 activities observed that the regular contact and training by the Project helped to develop positive attitudes toward the MW, but emphasized that the training cannot be a one-off event, and needs to be repeated with refresher training on a regular basis since there is constant rotation and turnover of staff.

12.5.3 Technical assistance (TA) and monitoring

There were sharp differences in the TA and monitoring between the two PHAMIT phases. Simply put, TA was more intense in PHAMIT 1 than in PHAMIT 2. Partly, this was the result of the delayed contractual process with the BHA in PHAMIT 2 which reduced confidence in the ability of this partner to deliver. The Project adapted by increasing long-distance TA by phone, and consultation at various forums, and occasional site visits as necessary. The PR provided TA to the SR during quarterly meetings and telephone, and this was mostly about management and data. Some of the SR arranged for Burmese physicians living in Thailand to provide TA to MHW and MHV.

12.6 Health services and access

12.6.1 Client-friendly services

During interviews, health care providers were vague about what inputs were provided by BATS or the PCMO to improve client-friendly services for MW. Nevertheless, ever since the start of PHAMIT 1, there have been continuous efforts to improve static site services for migrants, for example, by the posting of MHW at government hospitals and outlets to serve as translators, the creation of clinic times and locations specifically for the migrant clients in the hospital, separate screening exams and patient registration for migrants to make them feel more at ease, and facilitated referral for migrants within the hospital setting. However, the VCT and STI case management services for migrants were delivered through the routine clinics for all clients. MHW or MHV were on hand to help facilitate communication between client and provider, or help accompany the migrant client when needed.

12.6.2 Referral

The field staff, MHW or MHV helped facilitate referral of migrant clients among outlets or clinics in the network. In Project locations, most or all government hospitals and clinics were part of the referral network. Only in Mae Sot was there a special non-government facility (Mae Tao) which served the migrant population and where the forms and communication were in the language of the migrants (Burmese). Four MHW funded by PHAMIT though the PCMO were posted to this facility, given the large number of migrant clients.

12.6.3 Mobile VCT and STI services

The PR also provided funding for the operation of mobile clinic services through the PCMO to extend HIV VCT and STI screening to the MW communities at least once a quarter (in PHAMIT 1). In PHAMIT 2, the frequency of mobile clinic visits was scheduled to be twice a quarter. Nevertheless, in some locations there were time limitations of the mobile service and uptake was low. Also, those PCMO with heavy workloads could not always deploy the mobile unit as planned. In provinces with a large number of MW from Myanmar, some mobile units had a Burmese physician as part of the clinic team. This was a cause for concern by some staff since the clinic operated in the name of the provincial hospital, but the Burmese physicians were not legally-authorized clinicians.

12.6.4 Quality of care

Staff in some locations said that there was very little individual pre-test counseling for MW clients in some VCT outlets, since the emphasis was on post-test counseling. Pre-test counseling was sometimes done in groups. Speed of results differed by site. Some had same-day test results while others took two to three days to provide results. Most migrant VCT clients were followed up to obtain their test results. Some hospitals authorized Project staff who had been trained to conduct the post-test counseling and disclosure of test results. This was more convenient for some of the MW who could not often leave their worksite. Some VCT clinics were not very strict in protecting the confidentiality of test results and this could have reduced uptake of the service.

12.7 Health insurance

There remain significant challenges in increasing coverage of health insurance for the MW population. Part of the problem is the large number of unregistered (i.e., illegal) MW. The MOPH started a program in 2013 to sell health insurance to all MW (at a fee of 2,200 baht for adults and 365 baht for children under 7 years). However, the number enrolling has been quite low. Part of the reason is that the conditions of insurance are vague or variable across hospitals. Communication of central policy to the provinces has also been muddled and there are no unified standard guidelines for implementing this program. Thus, some hospitals set their own criteria (e.g., need to be a legally registered MW, with a 13-digit ID card or Thaw Raw 38/1 form, or pregnant women need to go through ANC first before obtaining insurance, or charging an additional premium for pregnant women who enroll, etc.). Some hospitals will only sell insurance for children if the whole family enrolls. The reason for these conditions is that, initially, only the ill MW were interested in buying insurance, but the hospital needs to spread the risk across the general population of MW, including those who are healthy. Otherwise, the insurance premiums would not be adequate to cover the cost of care. That said, some provinces like Ranong, with strong policy leadership from the

PCMO, have been successful in promoting the insurance program for a large number of MW, who can purchase insurance through any of the public hospitals, including the Tambon and the district, without conditions. They have also marketed the insurance to Burmese residents on the Myanmar side, in collaboration with their public health counterparts.

Another obstacle to selling insurance to the MW is that most are in good health and do not see the need for insurance and have other competing demands for their time and money. Some MW feel the cost of the insurance premium is too high when compared to their small daily wage. A special advantage of the MOPH insurance for MW is that, in principle, it covers ART. However, this may not be that attractive to the migrant population since very few have HIV or are at high risk. Also, the policy on reimbursing the cost of the ARV drugs is not clear and, thus, some hospitals exclude ART from the insurance benefits for MW.

12.8 Participation of stakeholders

The Project PR and SRs have organized a wide range of activities to create an enabling environment for service utilization and community participation. These include experience-exchange forums among NGO, health providers, the PCMO and private agencies. These events have increased as more Project experience and lessons learned have been gained. The Project has sponsored orientation and training for factory owners and staff who employ MW, the police, community leaders, and local organizations on such topics as labor rights, the health insurance system and other topics. However there remain barriers to mobilizing LAO and worksites to cooperate with or support Project activities since they do not have policies to provide health services for MW.

The personnel office staff of many factories and work sites have positive attitudes toward PHAMIT and are happy to cooperate and facilitate Project activities. But this collaboration is mostly lip service since the ultimate authority lies with the business owners and senior managers. When activities are allowed, the work site staff are not much involved, and merely observe the activity. Thus, this is one area of Project shortcoming. Other Project staff observed that some community leaders still have negative prejudice against MW, and view low-income foreigners as a source of social problems, disease and crime. Also, law enforcement is more concerned about fighting human trafficking of migrants rather than facilitating health care.

13

Summary, Analysis and Recommendations

The PHAMIT Project extended from 2004 through 2014 and was split into PHAMIT 1 (2004-2008) and PHAMIT 2 (2009-14). The Project had the goal to reduce HIV incidence among the population of cross-border migrant workers (MW) in Thailand from Myanmar, Cambodia and Lao PDR. The Project refined and expanded HIV prevention services and tailored these to the MW community to maximize access and acceptance. PHAMIT 2 had the following three objectives: (1) To strengthen and expand integrated prevention of HIV for MW at risk of HIV; (2) To create an enabling environment for HIV prevention with equal and sustainable access for MW with risk for HIV; and (3) To strengthen the strategic information system to promote improvements in policy and programs for high risk populations. This evaluation of the PHAMIT 2 Project is an essential part of assessing the lessons learned and achievements of the Project. To ensure objectivity, an external agency was contracted to conduct this evaluation: The Institute for Population and Social Research of Mahidol University. The results from the 2014 evaluation survey were compared with the baseline measures conducted at the beginning of PHAMIT 2 in 2010. Both quantitative and qualitative data were collected using the languages of the MW. The evaluation looked at the benefits which the MW derived from Project interventions, participation of the implementing partners, and improvements in the prevention environment. The results of this evaluation should help the key players to improve, expand and sustain the most successful components of PHAMIT so that the increasing number of MW in Thailand have access to health and prevention services as needed. This will benefit not only the community of the migrants but also the Thai communities they interact with on a daily basis.

13.1 Summary of the quantitative data collection

Sample characteristics

Most of the MW are in the younger cohort of the working-age population, as two-thirds were under 35 years of age, and an average of 28 to 29 years overall. The proportion of the sample MW that is male is slightly less than the females and this proportion was similar over the 2010 and 2014 rounds of the survey. Most of the women were living with their spouse and the proportion in this status increased over rounds for both males and females and for all three nationalities. Nearly all the MW had completed their education in their home countries, while a small minority continued their education after migrating to Thailand. There is clustering of occupation type by nationality. For example, jobs in fisheries or seafood processing are predominately held by Burmese MW, whereas few Cambodians are found in this line of work. The Lao MW in these samples were more likely to be working in agro-industry and factories. The MW from Myanmar and Lao PDR were more likely to have residence permits/ID cards whereas only a minority of Cambodian MW had residence permits. Overall, the proportion of MW with these IDs or permits declined over rounds, possibly reflecting the changing legal and policy environment for MW in Thailand as a whole (e.g., the Thaw Raw 38/1 form was replaced with temporary passports for MW). Average income increased significantly over rounds, in part due to the raising of the Thai minimum wage. Nevertheless, the average daily wage for MW is still less than the minimum prescribed by law, and the Burmese MW have higher daily income than the other two nationalities.

Knowledge, understanding and attitudes toward HIV/AIDS

Overall, HIV/AIDS awareness of the MW in these samples is good. The MW know that HIV is preventable, and that condoms are effective prevention, and correct knowledge increased over rounds. Knowledge of routes of HIV transmission also improved significantly over rounds. However, when looking at aggregate knowledge by measuring the proportion of MW who could correctly answer all five of the UNGASS basic AIDS knowledge questions, correct knowledge increased from one-fourth of MW in 2010 to only one-half in 2014. There was relatively low perceived self-risk for HIV in 2010, but this increased significantly for Cambodian MW among whom 41% perceived vulnerability to HIV in 2014. Those who perceive self-risk for HIV may wish to seek HIV voluntary counseling and testing (VCT), but it is important that they have confidence in the service. This evaluation found that, in 2010 and 2014, only two-fifths of MW felt that it was possible that their HIV test results would be kept confidential, the proportion doubting confidentiality increased over rounds.

More of the male MW felt that it is the man's role to carry condoms, and nearly 60% of both male and female Lao MW in 2010 felt this way, and also felt that a woman who carries condoms is immoral. However, by the Follow-up survey in 2014 only 38% and 50% of Lao males and females, respectively, felt this way. Also, it is interesting that nearly all the Lao MW felt that it was acceptable for the female in a couple to propose condom use. By contrast, only about one-third of Cambodian and Burmese MW felt that it was appropriate for a women to propose condom use to her partner, in both rounds. Access to condoms is not a problem for these MW, and over 90% of Lao MW in 2014 said they could get condoms when needed, However, 16% of Burmese MW in 2014 said that access to condoms was not convenient.

Knowledge and understanding of STI

About 90% of MW in both rounds knew that having an STI increases risk for transmitting or contracting HIV, though the MW from Myanmar had less awareness of this fact than their Cambodian and Lao counterparts. MW were asked if they had genital discharge or foul genital smell in the past year, and the proportion answering yes increased from under one percent in 2010 to nearly 8% in 2014. Cambodian MW reported more prevalence of these symptoms (4% and 15% respectively) and about one-tenth of Burmese MW and 3% among the Lao in 2014. However, it is noteworthy that only small percentages of MW with STI symptoms went for clinical diagnosis and care. If they were to go to an outlet, the MW in the 2014 sample preferred a Thai government hospital (62%) followed by a health center (18%), NGO clinic (7%), or private clinic (4%).

Receipt of HIV/AIDS information

Television is the preferred media channel for MW of all three nationalities in this evaluation, especially for the Lao MW who watch Thai TV broadcasts more than their counterparts from Myanmar and Cambodia. Print media are also a valuable channel for education since the MW can take the material home and study it at their leisure or with help from others. However, perhaps because of the low literacy levels among these lower-income MW, most reported not reading a newspaper in the month prior to the interview, and in both rounds. About half the MW received HIV/AIDS information in their home countries before migrating to Thailand. After arriving in Thailand about one-third of MW (or their family member) were exposed to an awareness campaign about STI and HIV in 2010, and this increased to about half in 2014. Coverage of the MW population with information about condoms was good (about two-thirds in both rounds). Routes of information include focus group discussion, training, booklets and brochures. NGO clinics were an important source of condom information and resupply, including the MHW and MHV. Exposure to

information about VCT increased over rounds, especially for Cambodian and Lao MW. NGO clinics were also an important source of VCT information, especially the MHW and MHV.

Sex behavior and condom use

Average age at first sex was constant over rounds at 21 years and, when looking just at the cohort age 15-24, the proportion with age at first sex under 15 years increased over rounds.

Sex with spouse/regular partner

More MW were living with a spouse or regular partner in the Follow-up survey compared with the Baseline (89% and 83% respectively). The largest increase occurred for Cambodian MW (from 66% to 89% living with spouse/regular partner). Ever having used a condom with a spouse in the past 12 months increased over rounds from 11% to 19%, and in all nationality groups. The Lao couples had the highest condom use (increasing from 25% to 30% over rounds). The principal reason for condom use with their spouse was to prevent pregnancy (about 82-83% in both rounds), while 10% and 15% reported using condoms for STI/HIV prevention (by round) and mostly among the Burmese and Cambodian MW. However, using a condom for every sex episode with their spouse/partner (among those who had ever used condoms with their spouse in the past year) was reported by 13% in 2010 and 15% in 2014. Impressively, use of a condom at last sex with spouse (among those who had ever used condoms with their spouse in the past year) increased from 68% to 92% over rounds, and for all three nationalities.

Sex with a non-regular partner and sex worker

MW who ever had sex were asked if they had sex with a non-regular partner in the 12 months prior to the interview. Over rounds, the proportion who had had sex with a non-regular partner was constant at 4%. More male than female MW reported having a non-regular sex partner in the past year and, by nationality the proportions increased from 5 to 8% for MW from Myanmar, 10 to 16% for Cambodian MW, and declined slightly from 16 to 14% for Lao MW.

Both survey rounds found that Cambodian male MW were more likely to have had sex with a sex worker in the past 12 months than the Lao or Burmese MW, but the proportion declined from 34% to 13% over rounds. Male Lao MW who reported buying sex also declined, from 10% to 7% over rounds. Burmese MW had the least history of buying sex in the past year: 3% and 4%. These differences could reflect the different proportions of single men, occupation or living conditions among the three groups as opposed to social norms.

The proportion of male MW reporting never using condoms with a non-regular partner in the past 12 months declined by half from 42% to 21% across rounds. By nationality, the MW from Myanmar reported a decline in never-use from 39% to 24% over rounds, and Cambodians reported 11% to zero never-use over rounds. Consistent (always) use of a condom with a non-regular partner increased over rounds from 35% to 47%. By nationality, the increase was 32% to 48% for Burmese MW, but Cambodian MW reported a decrease in consistent use from 80% to 60%.

Male MW who had sex with a sex worker in the past 12 months reporting using a condom for every episode increased from 75% to 79% over rounds. By nationality, always-use was about constant for MW from Myanmar (76% and 75%), and increased for Cambodian MW (75% to 80%). The number of Lao MW with non-regular or commercial sex partners was too low to provide meaningful results.

Of those who ever used a condom with a non-regular partner, condom use at last sex with a non-regular partner was constant for male MW at 77%. However, this average masks differences by nationality. Burmese MW reported increased condom use at last sex from 76% to 83%, but Cambodian and Lao MW reported decreases, from 86% to 73%, and 74% to 40% respectively (though the N for Lao respondents is very low). For last sex with a sex worker, the corresponding percentages of condom use are 93% and 94% over rounds for all male MW (who had sex with a sex worker in the past 12 months and had ever used condoms with a sex worker). By nationality the proportions reporting condom use at last commercial sex is roughly constant over rounds.

Reasons for not using condoms

Male MW who reported using drugs or an intoxicant (primarily alcohol) at last sex with a sex worker (among those who ever had sex with a sex worker) declined from 83% to 64% over rounds. MW were also asked if they thought condoms reduce the pleasure of sex. Most male MW said that condoms reduce pleasure of sex more with a non-regular partner or sex worker, than sex with their spouse. Confidence in (male MW) ability to persuade one's partner to use condoms increased from 38% in the Baseline to 64% in the Follow-up survey. MW were also asked what they would do if their partner refused to have safe sex. In 2010, over half of both male and female MW said they would consent to condom-less sex even though they preferred safe sex. But this proportion declined by 2014 for all groups. Most male MW would refuse to have sex if a non-regular partner refused to use condoms (doubling over rounds from 19% to 38%).

Voluntary Counseling Testing (VCT)

In 2014, MW were asked if they knew of a VCT outlet in the vicinity and 70% said they did, and this represents a significant increase over the proportion in 2010 (50%). Female MW had greater awareness of a VCT outlet than males in the Follow-up survey. Nearly two-thirds of those that knew of a VCT outlet said that it was a government hospital. One-third cited a health center and 14% said the VCT outlet they knew about was an NGO clinic. In 2014, over one-third of MW had ever gone for VCT (34% of males and 40% of females) and this represents a five-fold increase over the Baseline (38% versus 8%). The top three reasons for seeking VCT include requirement for job application, part of the ANC visit, and suspect risk for HIV (40%, 26% and 21% respectively). Three-fourths went to a government hospital for the VCT, but only one-fourth had gone for VCT in the past year. Surprisingly, in 2014, fewer MW who went for VCT in the past year received individual pre-test/post-test counseling compared with the Baseline (54%/44% and 60%/64% respectively). Further, the proportion who received their test results also declined from 94% at the Baseline to 85% in the Follow-up.

Family planning

Knowledge of the oral contraceptive (the pill) was nearly universal (96%) among the MW, both married and unmarried, and all nationalities and across rounds. Other methods known in 2010 include the injectable (80%), condom (72%) and female sterilization (68%). By the Follow-up in 2014, 91% of MW cited condoms as a contraceptive, followed by the injectable (87%) and female sterilization (70%). Also, all three groups of the ever-married MW had ever used a modern contraceptive, but the proportion ever using a contraceptive who had used the pill declined over rounds from 77% to 66%. About 40% of MW who had ever used contraception had used the injectable, and this was the same in both rounds. Among current users of modern contraception, the pill was the most common method (42% and 39% by round), followed by the injectable (21% and 18% by round). Most of the ever-married female MW reported having a child, and the proportion increased from 50% in the baseline to 77% in 2014, especially among the MW from Myanmar. Most of the MW women said that the decision to have a child was a joint decision with their husband. But fertility norms of MW seem to be declining as 39% of MW in 2010 said they wanted three children whereas 40% in the Follow-up wanted only two.

Access to health services

The proportion of MW with an illness/injury requiring clinical care in the 12 months prior to the interview declined over rounds from 90% to 85%. Patterns of health-care seeking were much the same over rounds with the government hospital being the preferred outlet, followed by health center and private clinic. It is noteworthy that a

significant proportion of MW reported going to a traditional healer and this increased over rounds. Reasons for not going to a government health outlet were the same over rounds, namely, lack of an ID/residence card, the long wait for service, or remote location of the government outlet. The principal reasons for not seeking care at a private hospital or clinic was the cost of care or lack of knowledge about the outlet. Of those going to a government hospital for care in the past year, two-thirds were “very satisfied” with the service and one-third were “satisfied”. Similar proportions reported that the service was either “very convenient” or “convenient”. About half of the sample in this evaluation reported having some form of health insurance.

13.2 Summary of the qualitative data collection

Management

The Raks Thai Foundation (RTF) is the Principal Recipient (PR) for the PHAMIT 2 Project, with eight SR: WVFT, FAR, Pattanrak Foundation, Stella Maris Seafarers Center, AIDS Network Development Foundation, MAP Foundation, the Social Development Foundation and the Bureau of Health Administration (BHA) of the MOPH. Ten PCMO participated as pilot sites: Chonburi, Rayong, Samut Sakorn, Samut Prakan, Tak, Chiang Mai, Pattani, Ranong, Songkhla, and Phuket (which later withdrew from the Project). In PHAMIT 1, there was an agreement for support with the MOPH as the SR, with the BHA overseeing management of public health activities of the Project partners. There was a rather close collaborative relationship among the partners in PHAMIT 1. However, in PHAMIT 2, there were changes in the management of some of the responsible implementing agencies, and within the BHA itself which made it difficult for it to honor its mandate for overall health administration of the Project. To accommodate this new environment, the managers of PHAMIT 2 decided to shift management authority to the PCMO in ten provinces, backed up by signed agreements with the PR, and accompanying budget. With these funds, the PCMO were expected to implement training of health staff to provide client-friendly services for MW, deploy mobile clinics to migrant communities for HIV VCT and STI screening, and develop strategic health plans for MW.

Mechanisms for strategic advocacy of the Project

Joint Strategic Management Committee (JSMC)

The JSMC was first established under PHAMIT 1 and met quarterly, and was designed to be a mechanism of communication among the Project partners for planning, strategic thinking, and trouble-shooting. The management board of PHAMIT 1 comprised managers from each of the implementing partners and the BHA. For PHAMIT 2, the board was expanded to include field managers but lacked a MOPH counterpart. The change in management structure over time had benefits and

drawbacks. In PHAMIT, the board members were all senior management with broad views of the program. While PHAMIT 2 brought in the field perspective, the field managers did not have the same broad vision as the senior managers. Thus there was more focus on progress reporting and trouble-shooting rather than strategic adjustments.

Provincial Coordinating Mechanism (PCM)

During the SSF Round of the GFATM, PCM were established to formalize provincial coordination of AIDS projects and provide strategic guidance and alignment. The focus of the program were the four vulnerable populations of MSM, FSW, PWID and MW. In addition children affected by AIDS were an ancillary target group. The CHAMPION Program was under the management of the NAMc of the DDC of the MOPH, with budget to support the PCM through the PCMO, as the secretariat. This evaluation found that the role and effectiveness of the PCM regarding projects for MW varied from province to province, depending on the strength and interest of key staff and the PCMO. Advocacy for the various target populations varied as well. There was considerable overlap in membership on the various coordinating mechanisms, including program, Project and provincial committees. Efforts by the PCM to consolidate and streamline some of this management may have reduced duplication but also may have limited the voice of the target populations. In other cases, the PCM became so big as to lose focus and become unmanageable in some respects.

The mechanism of PHAMIT MHW and MHV

The Migrant Health Worker (MHW) is the principal Project component for outreach, and these bi-lingual, (mostly) non-Thai personnel are funded by the NGO implementing partner agencies. MHW are classified differently by the different NGO (e.g., Field Officer Migrant, Front Line Social Network) but provide the same function across sites. Key tasks include serving as a liaison and link between the migrant client and the Thai health provider and some work as assistants to the hospital and clinic staff. Another key group is the cadre of Migrant Health Volunteers (MHV) who are based in the migrant communities and at some health posts or DiC. They receive no salary except for travel compensation when helping with outreach activities. MHV are important in motivating MW to participate in Project activities, managing condom resupply and distributing educational media.

Project outreach

Target populations

PHAMIT 1 focused on 18 coastal provinces and MW from Myanmar and Cambodia working in the fisheries industry and seafood processing. PHAMIT 2 expanded coverage to 14 additional provinces and included Lao MW as part of the target population. The MW occupations in PHAMIT 2 included fisheries, factory work, construction and agro-industry. Among groups, those working in agro-industry and construction were rather hard to reach with Project services. Also, the younger cohorts of MW had lower participation rates in Project activities. In addition, some MW married at a young age (e.g., 13 or 14 years) – and thus were vulnerable for RH problems -- but were technically not part of the Project which defined the target population as persons age 15-49. MW working in the entertainment industry and FSW were target populations in PHAMIT 1 but not in PHAMIT 2 because CHAMPION no longer gave priority to this group.

Outreach for behavior change

The outreach conducted by the SR NGOs consisted of awareness raising for increased prevention behavior and distribution of condoms and lubricant, and referral for VCT and STI case management. Implementation was generally similar across provinces, with the use of MHW and MHV as key liaisons for the outreach. PHAMIT 2 produced more educational media and in more languages, especially Lao. Information resource centers and Drop-in centers (DiC) were set up in or near the migrant communities as a meeting place for MW to exchange information, receive services, relax and socialize. The DiC differed by location to suit the local context. The Project organized free condom distribution for MW through a variety of channels such as small group education, outreach staff, MHW, peer educators, condom boxes at the DiC, campaigns, and condom dispensers at worksites, and other convenient access locations in the community.

Condoms

Staff said that supplies of condoms were adequate and improved in quality and features over time (flavor, color). But some MHW said the condoms were not always appropriate for some MW, and there was a need for more supplies of lubricant. The Project achieved its condom distribution targets. Staff and MHW said they observed indications of improved prevention behavior among the MW, and female MW seemed more confident in discussing issues related to sex and condoms, and some women even

came for resupply without embarrassment. However, use of condoms for preventing pregnancy among married couples was still low. Some staff observed that the dense living conditions of the MW, with some couples sharing a large room with only a curtain for privacy, might deter some to use condoms because of the noise in opening the packet, or leaving wrappers in the shared waste receptacle.

Family planning

In some locations, MW knowledge about RH is still limited, and PHAMIT 2 did not emphasize RH content as much as PHAMIT 1. Thus, some of these locations reported issues of unwanted pregnancy and abortion. SRs provided information on contraception and were able to receive supplies of the oral contraceptive from the PCMO and government hospitals for resupply to MW who had been prescribed the pill. Some MW women preferred the injectable since it is simpler, and usually went to private clinics for this service.

Capacity building

Project field coordinators and MHW/MHV

Field personnel received the standard Project training (5-day curriculum) once a year which included content on prevention and control of HIV/AIDS and STI, client-friendly services at health outlets, RH, family planning, counseling, public speaking, community preparation, etc. Some SR provided on-the-job training and mentoring through monthly and quarterly meetings, activity-planning exercises and budgeting, situation assessments, up-dates on labor laws, social security benefits, registration of MW, meetings with staff of other agencies on gender issues, counseling, health insurance, inter-personal communication skills, and distribution of handbooks and protocols as references. The MHV and peer educators received capacity building from the Project field staff and MHW. However, some sites did not implement formal training for the MHV and, instead, simply gave orientation at meetings or periodic group discussions to clarify roles and responsibilities, and how to deliver the basic package of HIV/STI/VCT knowledge. Some of the peer educators felt that they still did not have adequate knowledge or skill to inform and advise others in certain areas, such as STI. Most of their function was to invite and encourage MW to participate in Project activities, and to explain the process of screening for STI and HIV, and distribute educational media and condoms in their neighborhood. They also informed Project staff when they learned of someone who was ill or injured and needed clinical care.

Monitoring and technical assistance (TA)

There are sharp differences in the TA and monitoring between the two PHAMIT phases. Simply put, TA was more intense in PHAMIT 1 than in 2. Partly, this was the result of the delayed contractual process with the BHA in PHAMIT 2 which reduced confidence in the ability of this partner to deliver. The Project adapted by increased long-distance TA by phone, and consultation at various forums, and occasional site visits as necessary. The PR provided TA to the SR during quarterly meetings and by telephone, and this was mostly about management and data. Some of the SR arranged for Burmese physicians living in Thailand to provide TA to MHW and MHV.

Health services and access

Client-friendly services

During interviews, health care providers were vague about what inputs were provided by BATS or the PCMO to improve client-friendly services for MW. Nevertheless, ever since the start of PHAMIT 1, there have been continuous efforts to improve static site services for migrants, for example, by the posting of MHW at government hospitals and outlets to serve as translators, the creation of clinic times and locations specifically for the migrant clients in the hospital, providing separate screening exams and patient registration for migrants to make them feel more at ease, and facilitation of referral within the hospital setting. Even though the VCT and STI case management services for migrants were delivered through the routine clinics for all clients, MHW or MHV were on hand to help facilitate communication between client and provider, or help accompany the migrant client when needed.

Referral

The field staff, MHW or MHV helped facilitate referral of migrant clients among outlets or clinics in the network. In Project locations, most or all government hospitals and clinics were part of the referral network. Only in Mae Sot was there a special non-government facility (Mae Tao Hospital) which served the migrant population and where the forms and communication were in the language of the migrants (Burmese). Four MHW funded by PHAMIT though the PCMO were posted to this facility, given the large number of migrant clients.

Mobile VCT and STI services

The PR also provided funding for the operation of mobile clinic services through the PCMO to extend HIV VCT and STI screening to the MW communities at least once a

quarter (in PHAMIT 1). In PHAMIT 2, the frequency of mobile clinic visits doubled to twice a quarter. Nevertheless, in some locations there were time limitations of the mobile service and uptake was low. Also, those PCMO with heavy workloads could not always deploy the mobile unit as planned. In provinces with a large number of MW from Myanmar, some mobile units had a Burmese physician as part of the clinic team. This was a cause for concern by some Thai staff since the clinic operated in the name of the provincial hospital, but the Burmese physician was not a legally-authorized clinician.

Quality of care

Staff in some locations said that there was very little individual pre-test counseling for MW clients in some VCT outlets, since the emphasis was on post-test counseling. Pre-test counseling was sometimes done in groups. Speed of results differed by site. Some had same-day test results while others took two to three days. Most migrant VCT clients were followed up to obtain their test results. Some hospitals authorized Project staff who had been trained to conduct the post-test counseling and disclosure of test results. This was more convenient for some of the MW who could not often leave their worksite. Some VCT clinics were not very strict in protecting the confidentiality of test results and this could have reduced uptake of the service.

Health insurance for MW

There remain significant challenges in increasing coverage of health insurance for the MW population. Part of the problem is the large number of unregistered (i.e., illegal) MW. The MOPH started a program in 2013 to sell health insurance to all MW (at an annual fee of 2,800 baht for adults and 365 baht for children under 7 years). However, the number enrolling has been quite low. Part of the reason is that the conditions of insurance are vague or variable across hospitals. Communication of central policy to the provinces has also been confusing and there are no unified standard guidelines for implementing this program. Thus, some hospitals set their own criteria (e.g., need to be a legally registered MW, with a 13-digit ID card or Thaw Raw 38/1 form, or pregnant women need to go through ANC first before obtaining insurance, or charging an additional premium for pregnant women who enroll, etc.). Other hospitals will only sell insurance for children if the who family enrolls. The reason for these conditions is that, initially, only the ill MW are interested in buying insurance, but the hospital needs to spread the risk across the general population of MW, including those who are healthy. Otherwise, the insurance premiums would not be adequate to cover the cost of care. That said, some provinces like Ranong, with strong policy leadership from the PCMO, have been successful in promoting the insurance program for a large number of MW, who can purchase insurance through any of the public hospitals, including the Tambon and the district, without conditions. They have also marketed the insurance to

Burmese residents on the Myanmar side, in collaboration with their public health counterparts.

Another obstacle to selling insurance to the MW is that most are in good health and do not see the need for insurance and have other competing demands for their time and money. Some MW feel the cost of the insurance premium is too high when compared to their small daily wage. A special feature of the insurance is that, in principle, it covers ART. However, this may not be that attractive to the migrant population since very few have HIV or are at high risk. Also, the policy on reimbursing the hospital for the cost of the ARV drugs is not clear and, thus, some hospitals exclude ART from the insurance benefits for MW.

Participation of stakeholders

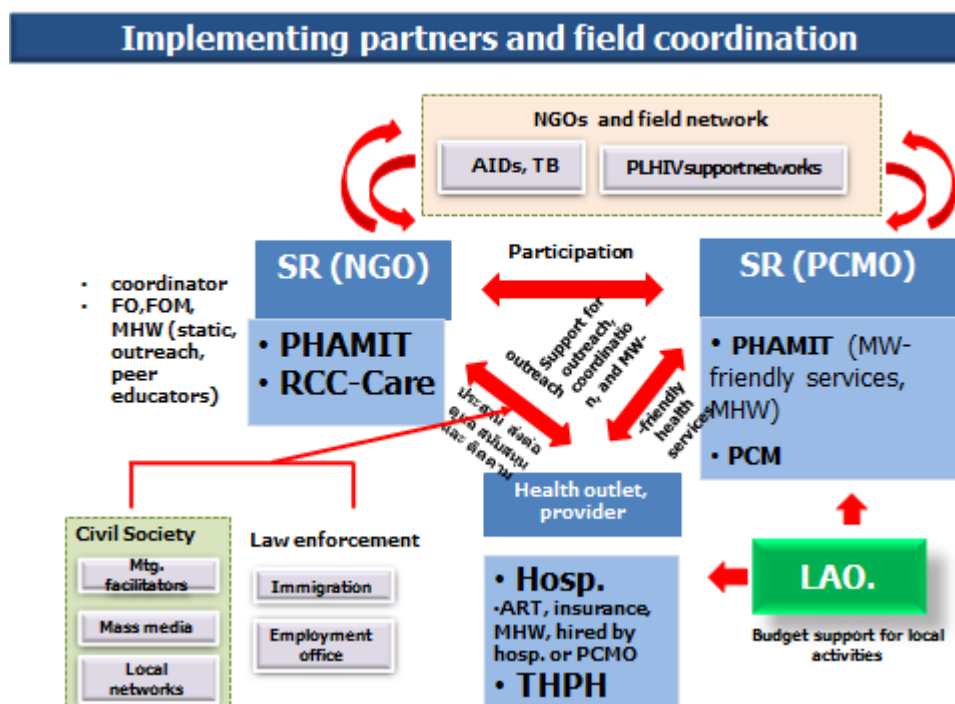
The Project PR and SRs have organized a wide range of activities to create an enabling environment for service utilization and community participation. These include experience-exchange forums among NGO, health providers, the PCMO and private agencies. These events have increased as more Project experience and lessons learned have been gained. The Project has sponsored orientation and training for factory owners and staff who employ MW, the police, community leaders, and local organizations on such topics as labor rights, the health insurance system and other topics related to MW. However there remain barriers to mobilizing LAO and worksites to cooperate with or support Project activities since they do not have policies to provide health services for MW.

The personnel office staff of many factories and work sites have positive attitudes toward PHAMIT and are happy to cooperate and facilitate Project activities. But this collaboration is mostly lip service since the ultimate authority lies with the business owners and senior managers. When activities are allowed, the work site staff are not much involved, and merely observe the Project activity. Thus, this is one area of Project shortcoming. Other Project staff observed that some community leaders still have negative prejudice against low-income foreign MW as a source of social problems, disease and crime. Also, law enforcement is more concerned about fighting human trafficking of migrants rather than facilitating health care.

13.3 Analysis of Project achievements

Figure 13.1 depicts the Project framework for field implementation and linkages.

Figure 13.1: Mechanisms of Field Implementation



Implementation mechanisms

PHAMIT 2 established links with the routine service providers and Civil Society as a mechanism for field coverage of the target population and coordination. Success with this model across Project sites varied. Some of this variation was due to local partner implementation, and other outcomes were due to the implementation environment and types of occupations of the MW. A key factor in success of the implementation model was the performance of the SR as the focal point for outreach and local networking. The SR was responsible for establishing and maintaining good collaboration with the local hospitals and assist with case-finding and referral. The PCMO themselves were a crucial element of the service provider network in their SR role of promoting and strengthening the client-friendly health services for MW, finding ways to fund the employment of MHW, and supporting the outreach activities and mobile clinic services. The outcomes of this coordination and implementation scheme depended heavily on the Project focal points in each part of the system. The more effective focal points ensured that there were regular consultative meetings, joint planning, and alignment of implementation. However, no matter how well this mechanism is

designed, if the coordination focal points are weak, then outcomes and achievements will not be optimal.

Civil Society also played a crucial role in PHAMIT 2. All the Project areas gave prominence to this sector, and Civil Society participated actively in key components, especially outreach. But intensity of implementation was uneven. All the field coordinators interviewed for this evaluation agreed that Civil Society was a visible part of the Project, but that the level of collaboration from this sector and law enforcement depended more on individual personality and context of each locality. Another key player were the local administrative organizations (LAO) who were expected to provide policy and budget support to replicate and expand Project activities in their area of jurisdiction. However some LAO supported the activities while others did not. Obviously, where LAO are supportive, there are good prospects for sustainability of the core Project interventions. Another approach to sustainability is to institutionalize some of the Project strategies and activities into the routine implementation plan of the province. Also the hospitals and PCMO have to be more effective in resource mobilization and writing grant proposals to augment government budget.

The network of NGOs were instrumental in AIDS networking. But mutual support and consistency of implementation across target populations and MW are essential for Project achievement. The PCM also plays a crucial role in sustaining collaboration and promoting a unified vision of the various implementing arms. But the strength of the PCM varies across provinces depending on the skill and motivation of the PCMO staff who are the secretariat of the PCM, and function like the host of AIDS programs in the province. Provinces in which the PCM is effective have regular meetings with all key partners in attendance, with joint brainstorming and planning between the public and private sector members.

The PCMO, hospitals and other government partners all praised the role of the MHW and MHV and want to find ways to sustain and expand their role. But, as noted earlier, it is not always clear where the budget for MHW salary and support will come from, or how to formalize this position in the public health personnel system. Some provinces are exploring tapping into the MW health insurance premiums to cover part of the cost of the MHW. But this would involve policy authorization at the central level. A similar challenge concerns the DiC which, if managed well and fully equipped and staffed, have good visitation rates and up-take of services. However, it is not clear how to support these DiC after PHAMIT ends. The hope is that Civil Society and the LAO will find the resources to maintain the more popular and cost-effective DiC.

As noted, where hospitals did not have separate clinics or spaces for MW clients, the MHW and MHV were indispensable in creating a client-friendly service for the MW. They helped to ensure that the MW got to the right clinic, processed the correct forms,

and reached the referral site for on-going care. For those MW who could not easily leave the community to visit the hospital, the Project made sure that there was a mobile clinic services for, at least, VCT and STI case management in all Project areas. This evaluation found that there are still too few VCT clinics that offer same-day results. This is a burden on the MW and possibly a deterrent to seeking VCT since the MW cannot take leave often from their jobs. Also, another deterrent to up-take may be the fact that some VCT sites do not strictly protect the confidentiality of the test results of the MW clients. The MOPH health insurance scheme for MW is a step in the right direction, but the annual cost (2,800 baht for adults) is prohibitively expensive for some MW, and some hospitals are reluctant to participate fully if they cannot ensure enrollment of a broad cross-section of the MW population (and not just the sick or infirm). Otherwise, the system will not be financially viable since any insurance scheme needs to distribute the risk among members. This is especially the case if HIV+ MW want to take advantage of the ART that is covered, in theory, by the MOPH insurance scheme. Thus, some hospitals are conducting pre-enrollment HIV screening of MW for health insurance and, if HIV+, may decline coverage.

Recommendations

- The Project condom campaigns should reflect and be tailored to the gender power dynamics given the different levels of gender parity and norms among the three nationalities;
- Campaigns for safe sex are up against social prejudices and need to withstand these forces by developing and implementing specific models and interventions that are appropriate and efficient;
- This evaluation found that some MW from Myanmar complained of inconvenient access to condoms and, thus, there may need to be an expansion of condom outlets or increasing awareness of existing outlets in the community;
- Some of the MW with STI symptoms reported that they self-treated or sought no treatment. Thus, there needs to be more motivation to seek appropriate clinical care when symptomatic;
- The proportion of MW receiving VCT has declined by 2014 when compared with 2010. Thus, there needs to be an intensification of motivation for MW with risk to seek VCT;
- Government policy is unclear about the path toward regularizing the cadre of MHW as part of the public health system in locations with large numbers of migrant clients. Currently, turnover of MHW is high because of lack of job security and low pay. Budget must be identified to properly compensate this workforce and institutionalize the position. MHW also need continuous capacity building and reinforcement;

- Some of the Project's DiC have low utilization rates, and may not be a cost-effective mechanism in those areas. There needs to be a secure source of funding to fully equip and staff the DiC that are popular and well-used in preparation for the end of PHAMIT funding;
 - Some VCT sites do not strictly protect the confidentiality of the MW blood test results. This could deter MW from seeking VCT. Thus, refresher training and more supervision is needed for VCT outlets for MW;
 - Some sites report that the local community leaders have negative attitudes toward MW, and view low-income foreign migrants as a source of disease, crime and social problems. Law enforcement officers give more priority to combatting human trafficking of migrants than supporting the RH programs of PHAMIT. There may be a need for adjustments of central policy to correct this imbalance of priorities and local reality.
-