

IMPACT OF SOCIO-CULTURAL FACTORS ON SEXUAL & REPRODUCTIVE HEALTH OF MIGRANT WOMEN

Findings from literature reviews in
Cambodia, Lao PDR,
Thailand and Vietnam, 2010 -2011

BACKGROUND TO STUDIES & METHODOLOGY USED



- Interest to explore impact of socio-cultural factors on SRH of migrant women; identify good practice in culturally sensitive programming for sharing
- Country focus:
 - international migration in Thailand (Burmese migrants)
 - internal migration in Cambodia, Lao PDR, Vietnam
- Reviews conducted of available literature (English and local languages); plus key informant interviews for supplementary information

DATA ON MIGRATING WOMEN



- Data is generally difficult to come by due to:
 - transitory/cyclical or impermanent nature of some migration
 - difficulty of counting irregular or undocumented migrants
- Global estimations:
 - internal migrants account for nearly 4 times the number of international migrants
 - 50% international migration is estimated to take place inter-regionally
 - 213, 943, 812 estimated international migrants (2009, UN Population Division)
 - 740 million estimated internal migrants (2000-2002 UNDP)

- Thailand magnet for migrants from GMS countries: estimated 1.8–3 million migrants (documented and undocumented)
- Vietnam, 1994 to 1999, 37% internal migrants were rural-urban, 20% were permanent rural to urban moves (GSO, 2001); 122,453 female migrants (2009 Census; though many categories not counted);
- Cambodia, 2004 census found 68.9% rural to rural migration, and 13.9% rural to urban migration (NIS); 1998 census: male migrants slightly more likely to have moved to rural areas, female migrants to urban areas.
- Lao PDR, internal migration more of a trend in the North compared with the South, with an increase in urban population of 17 to 27 % between 1995 and 2005

PROFILES OF MIGRATING WOMEN



- Mostly **young, unmarried** women moving from rural to urban areas
- **Not always** the ‘poorest of the poor’
- Usually have **some education**
- **Ethnic minorities** represented (Lao PDR, Vietnam, Burmese minorities in Thailand)
- Stated **reasons for migrating** include :
 - escape rural poverty
 - support parents and siblings at home
 - seek better economic opportunities
 - desire for a modern lifestyle, almost as a ‘rite of passage’ (Laos)

OCCUPATIONS

- **Factory work**, particularly in garment industry (Cambodia, Laos, Vietnam) although also in footwear industry (Vietnam), fishing industry (Burmese in Thailand)
- **Entertainment sector** - including beer sellers/ promoters, karaoke bars, discos (all countries)
- **Sex work**, direct and indirect, often linked with work in the entertainment sector (all countries)
- **Agricultural labour** (esp.Burmese in Thailand)
- **Domestic work** (in all countries, but almost no literature describing their experience)
- **Street sellers, traders etc.** (Cambodia)

STRUCTURAL BARRIERS

NATIONAL POLICIES HEALTH INSURANCE



NATIONAL POLICIES

- Policies (on national development, population, reproductive health, HIV, youth etc.) generally do not recognise the vulnerability of migrants or see them as being in need of protection
- In some contexts migrants are referred to in policy documents as representing the ‘negative’ side of development (Vietnam); others recognise migrants are vulnerable to STIs and HIV, but focus on the threat that they pose to others, rather than their own vulnerability

HEALTH INSURANCE

- Thailand – access to public services only if ‘registered’ international migrants (majority are unregistered)
- Cambodia – informal labour sector not covered by labour laws, so social security not available for many; National Social Security Fund decree signed (2007), health insurance decree not finalised
- Vietnam – health insurance determined by residency status; no regulatory system to track migrant movement, so lack of access in destination locations; domestic workers not insured
- Laos – Social Security Org. and Community-Based Health Insurance schemes available, but limited coverage; informal nature of migrant employment means they’re not registered

INFORMATION & SERVICE AVAILABILITY

SEXUALITY EDUCATION & LIFE SKILLS SRH SERVICES



SEXUALITY EDUCATION

- Previous access to sexuality education &/or life skills (in or out of school) could influence knowledge on SRH and access to SRH services for migrant women

However:

- Comprehensive sexuality education is not widely available (in Cambodia, Laos, Vietnam; and probably not in Myanmar)
- Where it exists, there's low capacity of teachers to address these 'sensitive' topics

SRH SERVICES

Services in rural & remote areas are basic, utilisation rates low; **private services and pharmacies preferred** (Cambodia & Laos); low utilisation by ethnic minorities in places of origin (Vietnam & Laos)

Migrant women who've accessed services at home, will be more likely to seek services in work destinations

But, **unfamiliarity with destination areas and location of services** limits uptake of public services

In Thailand **free services are available for registered migrants**; private practitioner alternative for others

RH VULNERABILITIES ASSOCIATED WITH MIGRATION



- Distance from home & absence of oversight role played through social norms can lead to **high risk sexual activity**, including unprotected sex
- **Unsafe abortions** often resorted to in cases of unintended & unwanted pregnancies
- **STIs and HIV** can be consequence of lack of skills for negotiating condom use, especially in cases of coerced sex in ‘entertainment’-related work

- Very limited data available on **pregnancy** in migrant women; poor access to health services likely to result in low or no access to **pre- and post-natal care**
- Reference made to unregistered Burmese migrants in Thailand without access to public services preferring to use **TBAs** for deliveries
- All reports referred to **violence** experienced by migrant women in and out of their workplaces (and on the ‘migration path’), but no data available

MIGRANT WOMEN IN THE SEX INDUSTRY : KEY FACTORS



- Many migrant women do not set out intentionally to become sex workers, some:
 - are influenced by peers, or attracted by higher wages in other jobs (Cambodia, Laos)
 - move to sex work when factory opportunities or other options fail (Cambodia , Vietnam)
 - ‘graduate’ to sex work from waitressing, selling beer or entertainment-related employment (Cambodia, Laos, V ietnam)
- Migrant sex workers fear social discrimination and stigma and are often reluctant to access public health services or outreach; oppressive laws are a hindering factor (all countries)

- Beer sellers/promoters are particularly vulnerable to pressure from employers & customers to sell sex; sometimes coerced/forced into having sex, or made to get drunk (Cambodia) or to take drugs (Laos)
- Perpetrators of violence against sex workers, including rape, are frequently 'officials', (police, border control officers etc.) sometimes in lieu of payment of fines, for 'protection' from prosecution etc. (Cambodia, Laos, Burmese in Thailand)
- Exposure to other health hazards: cigarette smoke, constant loud music, having to wear high heels (Cambodia, Laos, Vietnam)

- Migrants from certain ethnic minorities in N. Laos (Khmu and Akha) are particularly represented in the sex trade in Northern Laos, and are increasingly observed to use their income **to position themselves better in their own communities** through setting up small businesses, apparently without experiencing sanctions within home communities
- In some cases, **pre-existing cultural practices**, such as pre-marital sex, ‘serving’ visitors in different ways, means that traditional practices may ‘accommodate’ acceptance of sex work among certain minorities (Laos)

QUALITY OF CARE ISSUES

Service provider
attitudes

Availability of services

Preference for private
sector &
traditional
practitioners



Service provider attitudes often negative; migrants tend to be looked down on, esp. those in jobs associated with sex work (all countries e.g. associated with ‘social evils’ in Vietnam)

Availability/accessibility of services – inconvenient opening hours of public services (all countries)

On site facilities – very few (Vietnam, Cambodia with NGO support); factory employers often don’t allow workers to visit clinics during working hours, or dock their pay if they do so (all countries)

Private sector services including pharmacies offer convenient opening times, privacy & confidentiality, which migrants are willing to pay for; unsafe abortion providers common (Vietnam) and thro' pharmacies (Laos)

Preference for traditional practitioners and treatments associated with place of origin, esp. where access to public services is difficult (Burmese in Thailand)

Language can be a barrier (Burmese in Thailand, ethnic minorities)

SOCIO-CULTURAL INFLUENCES ON BEHAVIOUR

- Condom use associated with ‘bad’ or ‘illicit’ sex; migrant women don’t associate themselves with this image, so don’t use condoms (Vietnam)
- Embarrassment when asking for contraceptives, esp. for unmarried migrants and sex workers (Cambodia, Laos, Vietnam)
- Fear of ‘losing face’ due to providers negative attitudes; or through personal information being relayed back home through social / work networks (Cambodia, Laos, Vietnam)

INFLUENCE OF GENDER-RELATED FACTORS

Confucian influences

Cultural norms and
expectations

Double standards



Confucian-influenced values on women's roles prevail (all four countries):

- many women migrate as dutiful daughters **to support parents and family**
- **conflicting societal expectations** impact on migrant women who engage in work that's perceived negatively eg. sex work
- women conform to expectations that they should be guided by their husband /partner's decisions on contraceptive use etc.
- migrant sex workers who aspire to marriage often forego use of condoms with 'sweethearts' who promise to marry them (Laos, Cambodia)

Double standards: a high value is placed on female virginity; conversely, men are expected to have many sexual partners and frequently visit sex workers

Migrant women are **expected not to be familiar with condoms**, nor to have the skills to negotiate their use

Due to cultural norms, sexually active unmarried female migrants prefer **not to use public health services** for fear of being criticised

Women working in ‘service/entertainment’ related jobs are **expected to wear ‘sexy’ clothes**: short skirts, high heels

POTENTIAL ENABLING FACTORS & EXAMPLES OF GOOD PRACTICE

Social networks

Clinics in factories

Client-friendly services

Peer education

Addressing VAW



- Social networks play significant role from source to destination in terms of:
 - securing employment
 - assisting in settling
 - finding accommodation
 - establishing friendship groups
 - maintaining contact with home
 - providing contacts for health care

Such networks can be better utilised to promote behaviour change and positive health-seeking behaviour through support groups, peer education, SRH training in places of origin

- Work based facilities provide the opportunity for employees to access services on site; care should be taken to ensure:
 - they offer a full range of services
 - workers time is not docked when visiting
 - clinic staff do not abuse the system by sending unwell workers back to work
- Peer education in work sites has proved successful, including distribution of condoms, contraceptives

Client-friendly service provision (mostly tested & used in Thailand in the context of Burmese migrant workers)

- Training of migrants as outreach workers & translators to serve as inter-face between clients & facility staff
- Mobile teams reach out to migrant communities
- Drop-in centres available in migrant areas
- Convenient opening times in facilities

Migrant service providers (Mae Tao clinic, Mae Sot Thailand)

Addressing violence against women

- *Automatic Response Mechanism* - a ten-step guide for coping with sexual violence (MAP Foundation, empowering Burmese migrant women in Thailand)
- A beer company (Laos) does not allow female staff to sit, drink or eat with clients, & transport is provided to and from work to protect them from sexual harassment or violence.
- NGO & beer company (Cambodia) trained workers on issues of gender & sexual relationships, negotiation & life skills, contraceptive use, safety in the workplace & SRH information.

POLICY ADVOCACY

- Migrant issues should be included in all relevant policy documents
- Health insurance should be available for all
- Campaigns should be launched to raise awareness on violence against migrant women
- Emergency contraception should be made available
- On site health facilities should be made available in work places or referral arrangements made
- Media should promote positive images of migrants & and their contribution to economic development rather than perpetuating negative myths

SUMMARISED RECOMMENDATIONS



KNOWLEDGE BUILDING

Additional research should be conducted on issues relating to migrant women's access to SRH information & services, in places of origin and destination. Findings should be used to:

- inform policy development
- inform curricula content for upgrading skills of health service providers
- strengthen law enforcement through the promotion of employees' rights in workplaces & for sex workers
- inform the development of services to address needs of migrant women who experience violence.

COMPETENCY STRENGTHENING

- Health service & other providers should be strengthened to understand gender dynamics and socio-cultural influences related to SRH
- Training should be provided in counselling & culturally sensitive, migrant-friendly, non-discriminatory health provision, addressing issues such as client confidentiality, stigma and discrimination
- Migrant workers should receive relevant culturally sensitive BCC & IEC materials with details of SRH information & services, in acceptable formats