have been changed nearly every year to tune into the real situations and promote the higher rate of migrant turn-up. For example, the processes were divided into issuing a residence permit and applying for work permit which has three kinds of duration – three months, six months, and one year, while the registration fee has been decreased[5]. In 2004, In Tak province, around 120,000 migrants were registered, and among them, around 56,000 migrants were registered in Mae Sot (Interview with the chief officer of the Tak Immigration office) [6]. Given the assumption that the population of the Burmese in Mae Sot is over 100,000, still many people are not registered yet, let alone holding work permit.

The state more often than not uses coercive means to control the town and its vicinity by the use of state agencies - the police and the military. To the vulnerable people, the presence of these agencies is the most fearful factor in their everyday lives. The police often raided the residential compounds of the migrants. Whenever it happened, the migrants ran away to other places and hided themselves until the police left. In the case of encounter with the police without time of hide, they were often kicked, bruised and extorted by the police. Their livelihoods were so fragile and vulnerable for the force of the state.

A news report shows an example of the treatment of the migrants by the state agencies,

> Security forces stormed a temple in Mae Sot district yesterday and arrested 320 Burmese workers at a garment factory who had been on strike since last Thursday.

[5] In the process of registration, the initial check up costs 600 baht and 1,300 baht for health insurance. The total paid in fees is 2,450 baht for a three month work permit, 2,900 baht for a six month one, and 3,800 baht for a one year one. Under the old registration scheme the yearly fee was 4,450 baht (Arnold, 2004: 17)

[6] In the whole Thailand, in 2004, 1,141,392 alien workers – 810,285 Burmese, 173,775 Lao and 157,332 Cambodians – were registered. Bangkok ranked first in the number of registrants with 190,000, followed by Tak, Samut Sakhon, Chiang Mai, Ranong and Chon Buri (Bangkok Post, August 1, 2004). It is estimated that still 840,000 migrant workers are not registered (Arnold, ibid: 17). Among the registered, as of late 2004, roughly 500,000 workers have registered for work permits (http://www.amrc.org.hk/5306.htm). In Tak Province, as of March, 2004, there had been 35,000 work permit applications (http://www.irrawaddy.org/news/2004/mar20.html). It means that majority of the Burmese people illegally engage economic activities in the Province, mostly in Mae Sot without work permit.

> All lost their work permits, became illegal immigrants and were deported to Burma. About 50 labor officials, border patrol and local police were involved in the raid (Bangkok Post, December 18, 2003).

A statement also describes the adverse circumstance that the migrants face[7],

> Murders, rapes, abductions, torture and other abuses of Burmese migrant workers in Thailand have occurred with alarming regularity for many years, particularly in the Mae Sot district of Tak Province, but for a long time only cases of extreme brutality were ever made public. In January 2002, for instance, the bodies of at least 21 persons were found in the Mae Lamao stream. No one has ever been brought to account for that atrocity…In the past year, abuses have increased, as impunity has spread in Thailand with new government policies favoring extra-judicial killing [in the war on drugs..], and because migrant worker's rights have been further curtailed.

The first full-scale deportation of the Burmese migrants was conducted during the economic crisis on the grounds of settling down the rising unemployment among Thai workers, which gave legitimacy for the arrest and repatriation of migrant workers (Koetsawang, ibid: 163). Since then, regularly or intermittently, massive and small-scale deportations have been taking place. In June 2003, Thailand and Burma signed the Memorandum of Agreement (MOU) under the terms of which every month Thailand is required to deport 400 Burmese nationals to a holding center in Myawaddy, Burma through the Thai-Myanmar Friendship Bridge. While formally the Thai government sends back 400 Burmese every month to Burma through the check point, however, informally approximately 10,000 Burmese people who are arrested in other parts of Thailand such as Bangkok are deported monthly by boat from unofficial border-crossing points along the Moei River (Interview with the chief officer of the Tak Immigration office).

The everyday lives of individual migrant people are heavily influenced by this deportation practice of the government. Most of my interviewees have been checked by the police and deported to Burma. One of them sarcastically called the police "the

[7] It was a written statement that the Asian Legal Resource Centre (ALRC) sent to the United Nations Secretary-General on 29 January 2004 (Arnold, ibid: 29).

migrant-haunting ghost". In their day-to-day lives, the migrants have to survive the chasing of the ghost.

Given the fragile and venerable condition elaborated above, still a question remains to be answered. Why is it that even though the state practices the migrant-expelling policies, the migrant system explained earlier is still operating, not dismantled by the state? Why can the state not fully control the border town? How should we explain the pictures described in the first part of the paper?

Bluntness of Tentacles: Localization of State Agencies

The state does not directly engage in establishing its regulation into a particular area. It needs the agencies through which it carries out its vision in the place. In the process of implementing its policies from the central to the local, inevitably the certain degree of deflection from its original intention takes place. As long as the political system of the state is centralized and therefore, regulations and acts are devised and ordered by the central, the difference between the initial aspiration of the state and the actual performance in the local continues to exist.

The agencies of the state, including the local government sectors, are located in the middle between the central and the local. While on the one hand, they have duty to fulfill as the representatives of the state what it commands, on the other hand, their everyday lives are rooted in the conditions of the particular place, and therefore, they cannot help but mingling with the local people whether they are citizens or illegal aliens. The agencies cannot transparently complete the policies of the state because they have already established relationships with the local people and in turn themselves are influenced by these policies. It is here that the tentacles of the state lose sharpness.

Steps of Localization

This localization does not come into existence within the period of short time. Time duration of its process is long and it goes through various incidents with trials and errors.

The process of localization of the state agencies can be divided into three steps. The first step is the period of actively carrying out their missions ordered by the state. Either when those agencies that are already positioned in the particular area get new commandments from the state or when new agencies are posted in that area in replacement of previous ones, their expectation of accomplishing their job is very high. Therefore, they strive to strictly enforce control in that area with uncompromising attitude to the exceptional and specific conditions of the local. I saw a newly positioned security guard of a refugee camp in the vicinity of Mae Sot rigidly control a gate, which previously was open even to outside people, with thorough investigation of people passing through it. Due to his strict enforcement of the rule, many activities were delayed or cancelled.

The second step is the period of conflicting, negotiating, and compromising with the situations of the local. In carrying out their duty, they more often than not confront obstacles which reflect the very local condition. When they deported massively Burmese illegal migrants during the economic crisis, local businessmen complained about the shortage of labor force, resulting from the deportation. Local shopkeepers in the central market of the town are strongly opposed to the police checkup toward the Burmese around the market because whenever it happens, their income level plummets. So many webs of relationships and the thickness of them overwhelm and hinder them from transparently conducting their mission. There are such cases that they happen to arrest migrants who work at a shop of one of their friends or relatives. If they deport the migrants, their close people would be in trouble. Even as the agencies benefit from the hiring of the migrants at their home or private business sectors, the deportation of the Burmese migrants definitely affects themselves.

Even if they determinedly keep trying to accomplish the policies of the state, the fruitless outcomes of their practices discourage them to continue their duty. It is obvious in the circumstance of the town. Though they send the migrants back to Burma today, tomorrow they cross the river and get into Mae Sot again. A Thai soldier acknowledges that the deportation of the Burmese is meaningless. Many of the state agencies in the town share the same opinion about the real outcomes of the state policies.

The third step is the period of stabilization. After experiencing the series of their unfruitful consequences, they have adapted themselves to the reality of the particular local. To their eyes, the presence of the illegal migrants is not abnormal any longer, but normal. They recognize that the migrants are one of important elements that consist of the structure of the border town. Though still they have orders from the state, they just carry out those duties without genuine alignment to the intention of the state. The activities of checkups and deportations become rituals that the police seasonally conduct in the absence of original meaning of them. Only minimal or reluctant activities to meet the quota that the state allocated or the MOU stipulates are conducted. The ideological rhetoric that the state imposes is not consonant with the local agencies in the remote border town. Their realistic perception overpowers the patriotic or nationalistic ambition of the state.

Factors of Localization

First, above all, the geographical peculiarities of the town's vicinity need to be mentioned. The borderline between Thailand and Burma is so porous that people's movement across the two countries easily takes place. People do not necessarily cross the border by officially recognized ways. The Thai-Myanmar Friendship Bridge is just one of many border-crossing points along the borderline, though the Bridge officializes the movement of people to certain extent. Still many Burmese people make unofficial or unauthorized border-crossings by boat along the Moei River. Especially during the dry season, people just walk through the river or swim to cross the border. Under the circumstance, even though they are deported, it is not very difficult to cross back the border. The deportation has only the effect of deterring or discouraging the crossing-back to minimal degree, but cannot totally block them from re-entering.

Second, culture is also an important factor. Mae Sot has had long-existing relationships with Myawaddy. From the far past, the mingling of people and culture has been taking place. One of my Thai informants mentioned, "Burmese people are our neighbors. Families, relatives, and friends are living across the two sides. How dare and

unreasonable it is for the government to make them apart in an attempt to divide the border!" In the town, it is often observed that similar culture between two countries nullifies the police checkups. For example, during such festivals as Songklan[8] and Loy Kratong[9], the Burmese get together with the local Thai people, enjoying the exhilarating events of the festivals, while the police just let them celebrate them, even safely guarding them not to be injured by the packed crowd. This ironical picture is also seen in other festivals such as the King's birthday and the Queen's birthday, though they are not Buddhist ones. Festivals play the role of mixing the aliens with the locals and furthermore they turn the role of the police and other state agencies from searching for the migrants to safeguarding them.

Third, in terms of social relationships, some of local agencies are under the influence of local big men. As the agencies do social activities apart from their job-related ones, they are involved in many informal and social organizations according to ethnicity, hobbies and interests such as Chinese community and sports clubs. It is not a rare case that local tycoons are in charge of expenses spent in the activities of those social organizations and tend to promote the well-being of the members by their money power. In doing so, local agencies are obliged to the big men and trapped in so-called "patron-client" relationships. This attitude affects their job performance. Therefore, even though they see their big men hire illegal migrants, they do not or cannot engage in this illegal employing. To do that would damage their social network and cause them difficulties living in the society. The patron-client relationships deter them to carry out the mission of the state.

Last but not least, economy is also an important factor for the localization of the state agencies. Already the economic system of the town is heavily dependent on the migrants. Overall 160 factories in the vicinity of Mae Sot are hiring over 30,000 Burmese workers with small number of Thai people. Besides, almost every shop in the town employs the Burmese migrants. Even at the houses of the local, Burmese people are working as

[8] It is held in April. It is the Buddhist New Year festival. It is also called Water Festival.
[9] It is held on the full moon night of the twelfth of lunar month (usually in November). During this festival, people float a lotus-shaped receptacle on the water. It has also Buddhist origin

domestic workers. They are not just workers but also considerable consumers that contribute to the income of local shop owners. Though most of factories hire legal workers, the portion of illegal labor in the town's economy is much greater than that of legal labor. It is not exaggerating to say that illegal or undocumented labor is normal and common in the context of the town. Given the above situation, to expel all illegal migrants from the town would definitely cause the collapse of the economic system of the town.

Patterns of Localization: Condoning, Cooperation, and Corruption

The localization of the state agencies can be categorized into three patterns: condoning, cooperation, and corruption. First, let me deal with condoning. As shown earlier, the state agencies went through the naturalizing steps of the specific conditions of the town. Now, to the eyes of them, the presence of the illegal aliens is rather normal phenomena. They do not rush to catch the migrants. They just let them wander around the town, shop at the market, drink tea at Burmese coffee shops, and play football and sepak takraw at vacant lots of the town. The agencies know very well that many shops and houses are employing illegal migrants, but they condone these illegal activities. Also they know very well that Burmese people are crossing the border by illegal ways, but they condone these unauthorized border-crossings.

Second, it is often observed that certain level of the cooperation of the state agencies with the migrants in some sectors takes place. For example, local health authorities cooperate with the Mae Tao Clinic, sharing information and providing medical treatment for special migrant patients (Interview with Dr. Cynthia). Local administrative authorities allow the Karen to have their New Year ceremony at a monastery in the town[10]. As I mentioned earlier, during the festivals, the police secure them not to be hurt by crowed people. The migrants are not discriminated in local sports competitions. Rather they are encouraged to participate in those events even though they do not prove their legal stay in the town.

(http://www.thailand.com/travel/festival/festivals_loykratong.htm).

[10] It was held in January 10, 2005. Many people involved in the KNU organized the ceremony. Year 2005 is year 2744 in Karen catalogue.

Third, while condoning is a neutral attitude to the migrants and cooperation is a positive one to them, corruption is the negative pattern of localization. Some of the agencies extract material gains from the local people and the migrants in return for letting the migrant system operate. Many of those arrested by the police were released after bribing at least 500 baht the amount of which is quite considerable in consideration of the general income level of the migrants[11]. There are some cases that notorious agencies extort all that migrants have. If we consider the condition of the border that unofficial and informal sectors comprise large parts of the town, it is easily expected that bribes are one of ways of keeping those sectors existing.

Conclusion

In foregoing sections, I have dealt with why the state cannot control the border town and how state agencies have adapted to the particular conditions of the town. I drew attention to the localization of the state agencies in doing that.

I have analyzed the coexisting systems in the border town where the state has special interests in establishing its rule against illegal aliens who appear to hurt the national integrity. Then, I have dealt with the approaches of the state to the town, elaborating various controlling means of the state. I have revealed that the state cannot fully control the town because, as time went on, its edge lost sharpness and became blunt in facing the hardly-breaking conditions of the town such as geographical, cultural, relational, and economic traits. Also this study has dealt with the patterns of localization; condoning, cooperation, and corruption.

This study contends that localization explains the paradoxical juxtaposition of the Thai system and the migrant system that illegal people constitute. It is localization that sheds lights on understanding of difference between state aspiration and actual performance.

[11] Male workers in construction sites get 90 baht to 100 baht a day, while female workers in same sites get 50 baht to 60 baht. Factory workers make 120 baht to 130 baht a day.

Existing state-society approaches assume that the state directly wage battles against the society to establish and enforce control in the society. In doing that, the role of the state agencies and their adaptation to the situations of the particular society has not drawn attention much. Unlike that, this study focused on the modification of the state agencies into the conditions of the society in carrying out the missions of the state. My approach would be influential into dealing with state-society relationships as it situates the agencies in-between state and society, linking two of them. Only when we focus on the role of the state agencies, we can be aware of various modes of ramification of the initial state aspiration.

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Consequences of migration for Lao Migrant workers in Thailand and their left behind families in Laos

A Case Study: Vientiane City, Khammoune and Savanaknet Province

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Theme B: Labor Migration

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Introduction

The phenomenon of population migration is as old as the history of mankind. People and whole societies have moved across continents regions and within a nation, in search for resources such as food, consumption, clothes etc. Migration is also a multidimensional problem. First as a demographic problem, it influences size and composition of population of origin and destination. Socioeconomic problems is one of the main causes of population shift is due to socioeconomic development imbalances between areas and regions (Goldscheider, 1969). The different economic growth in the region is the cause of population movement such as in China, where the population moved from island areas toward the east and from rural toward urban areas and open zones because those areas had industrialization, employment, and higher income (Cindy,1999). Lee (1985) mention that intention to migrate, not migration itself, all contextual characteristic, especially those related to socioeconomic development, affect the role in migration of individual and household attributes. The most commonly cited caused underlying population movement are: low income at the place of origin and expectation of higher earnings at the place of destination, unemployment, underemployment or dissatisfaction with present job at place of origin and expectation of better employment opportunities at the place of destination, search for fertile land and relative poverty of rural areas in the hill and on mountains. (N.C.P. 1997)

Lao PDR is located in the Center of the Mekong Sub-Region and shares borders with five countries which have different political regimes, culture and levels of economic development. Because of the specific location of the country, the Lao PDR has become the Transfer Point Center from one country to other countries in this region. Therefore, the Lao PDR could be an original and destination country for migrant workers from neighboring countries.

The main portion of Lao migrant workers has gone to work to neighboring countries, especially to Thailand, because it has similar culture, custom and language. The specific geographical location has facilitated migrants to cross borders from one to another country. Generally, there are different types of Lao migrant workers abroad. These people may have various consequences which can be identified in to two categories: advantages and disadvantages. Therefore this study focused on consequences of migration especially

for living and working condition of Lao migrant workers working in Thailand and their families at home.

Case study: In the Lao PDR, the provinces where there are more migrations to Thailand are: Bokeo, Xayabouly, Vientiane, Vientiane Capital, Borikhamxay, Khammoune, Savannakhet, Saravanh and Champassack[1]. However, this study has selected only three villages in three districts and three provinces namely: NongBeukTay Village, Sikhottabong District in Vientiane Capital City; DonKhouang and Nakham village, Nongbok District in Khammoune Province; and NateuyNeua and Phai Village, Champhone District in Savannakhet Province. The reason why we had selected these districts is because the number of villagers from those villages who had gone to work in Thailand is much more than from others villages.

The research examined the following questions. What are the main factors influencing Lao migrant workers to go to Thailand? What are the living and working conditions of Lao migrant workers in Thailand? What are the consequences of migration for Lao migrant workers in Thailand and their families at home?

Data and Method: The study was conducted using a combination of literature/reports review, participatory field visits which applied the questionnaire form for semi-structured interviews to interview the local authorities including the head and deputy head of villages, village police, head of the Lao Women's Union, Lao Youth Union and key informants. For household interview we selected 30 head of households, and those who have the family members working in Thailand (migrant's parents). For the interviewing terms, we use household questionnaire. The focus groups discussion (FGD) In each village we selected 6 interviewees per group (five villages/five FGDs) and used guided questions to interview and these were tape recorded.. For analysis we used the data from semi-structured interviews, household interviews and focus group discussion to describe and analyze.

The main outcomes of interest in the study are: (1) the statistic of foreign migration in Laos and Lao migrant workers working in Thailand 2004; (2) group of Lao migrant workers going to Thailand; (3) the main factors influencing Lao migrant worker going to;

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[1] Report on Lao illegal migration in Thailand. N0 909/2003.

(4) Occupation of Lao migrant workers in Thailand;(5) working situation and consequences of Lao migrant workers in case study (three villages) ;(6) the situation of their families in the left behind in Laos;(7) the positive and negative consequences of migration on their families.

The General information of Migration in Lao PDR

In 1986, the Lao PDR government adopted the New Economic Mechanism, which opened up the country for international economic cooperation. Economic activity shifted from a central command system towards a market-oriented based approach allowing the private sector to play an increased role in socio-economic development. The government promoted commercial production for export and substitute importation and others. The implementation of this government policy increased foreign investment which provided a number of job opportunities for Lao people. At present, there are foreigners who have migrated to work in the Lao PDR , but we do not have clear data on these foreign workers. For example foreign labours married to Lao people and who stay permanently in Lao (do no return home). The number of migrant workers who are registered at the Ministry of Laborand Social Welfare in the Lao PDR are showed in table 1 bellow:

Table 1: Number of Foreign Migrant Workers in Lao PDR

Countries	2004	2003	2002	2001	2000	1999	1998
China	-	685	899	539	855	533	709
Vietnam	-	319	581	885	1676	740	667
Thailand	-	367	520	410	641	667	529
Malaysia	-	42	33	14	16	32	23
French	-	50	37	48	55	53	62
India	-	33	24	29	27	90	23
Singapore	-	4	6	5	6	6	6
Others	-	213	295	325	248	278	445
Total	-	1731	2383	2207	3524	2399	2464

Source: Annual Report 2004, Department of Labor, Ministry of Labor and Social Welfare

The foreign labor in the Lao PDR mostly work for a number of capacities such as: experts, businessmen, accountants, workers and others. These foreigners have entry visas for their business activities in Lao, for short and long term. At the same time, Lao people also travel

abroad, for example as tourists, visitors, on business missions and for other purposes, and this trend seems to be increasing.

Table 2: Number of Foreigners with Lao Visas and Lao Holding Passports

Countries	2004	2003
Business Lao (BL) to Foreign Countries	1,645 pieces	3,428 pieces
Business Foreigner in Lao PDR	5,412 pieces	8,143 pieces
New Passports and Visa to Foreign Countries	100,406 pieces	40,504 pieces

Sources: Department of Consular, Ministry of Foreign Affairs (2004)

The new economic mechanism continuously increased the economy of the country, and the level of living has been improving step by step. The big cities have been developing in many fields, especially infrastructure facilities such as: hospitals, schools, electricity, water supply, entertainment and tourism resources. Nevertheless, there are developments in many sectors but only in the urban areas that differ from the rural such as: government education, private education, higher level education, universities, and factories. The factories are located mainly in the larger towns. The issues mentioned above are pulling factors for migration labor from rural to urban areas and the capital city Vientiane. According to data given from migration department, Ministry of Interior from 1995-2000, the number of migrants to Vientiane were 95,332 persons (migration authority control unit 1995)[2]. One of the reasons for migration is to look for jobs, for skilled labor, capacity building, to discover modernization of other foreign countries, and in some cases migrants follow their families and relatives.

The information is very limited so that we could not estimate the actual number of migrants. According to the population census in 1985 and 1995 (data survey for study 1995)[3], and from estimations of the province where there are more migrations for example: Phongsaly, Luangphrabang, Huaphanh, Xiengkhuang, Champassack and Attapeu.

The data information of migrations between country to country and the Lao legal emigrants are not quite clear. For example how many Lao migrants are there and which country do they go to? And how many immigrants are there in Lao? Therefore we do not

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[2] The Migration Authority Control Unit (1995)

[3] data for study research (1995)

have data for comparison. Currently, there are some Lao migrants married to foreigners, and married to migrants themselves. Most of them work in neighboring countries like Thailand because Thailand has similar language, similar culture, and life style. Those workers are legal and illegal. The number of illegal migrants is greater than legal migrants. The Ministry of Labor and Social Welfare of Thailand reported that the numbers of Lao laborers is about 200,000 persons, but the numbers of registered workers are approximately 181,641 persons in 2004[4].

The reasons for Lao migration to Thailand are: economic, they need to earn more money after harvesting of their productions; some were propaganda/persuaded by those whose have gone already; some are voluntary and involuntary; and some are persuaded by their parents, and others[5].

As we know migration results in the social differentiation of lives, for example labor migration from rural areas to the city (Vientiane capital), labor from the big cities migrate overseas for work and labor from destination countries go to others countries.

Lao workers in Thailand perform the work that Thai people don't like to do. For this reason Thai employers are lacking local labor on the other hand Thai employers are also looking for low salary workers from abroad such as labor from Lao, Cambodia and Myanmar, because their wages are rather cheaper than those of Thailand[6].

For more than two decade, Lao migrant workers have been working in Thailand. In general those workers come from each province of the Lao PDR, particularly from the border provinces of Lao-Thai which are easy for them to cross the border

A Review of Lao migrant workers working in Thailand

At present, the trend of Lao migrant workers seems to be increasing. The majority of migrants are from the provinces located along the Mekong border. Referring to the Statistic Research Center of Thailand in 1998 there were 12,000 persons, and the first registration of migrant workers who were working in Thailand, they found that in 2004 Lao migrants workers increased to 59,358 persons out of which there were 33,587 females. In the same year the second time there were 42,186 persons, female 24,960 persons. Third time, there

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[4] Minutes of Meeting on Consultative Meeting between Lao and Thai Authority on Identify Nationality of Illegal Migrant Workers on 13 September 2004

[5] interviewed Mr.Boutha, village head of Nongbok, Khammuane Province, dated 16/10/2004.

were 32,009 persons and the last time at the end of 2004 we found that the total number of Lao migrant worker were 181,614 persons including 80,981 females[7]. All totals mentioned above are referring to the migrants who were registered since the government of Thailand approval for legal working.

Lao illegal labor in Thailand is hard to control because migrants have gone by themselves (undocumentation). A number of them used tourist visas to enter into to Thailand and worked there illegally. Many of them don't have any document or have fraudulent documents. On the other hand the Lao PDR is located along the Mekong River, around 1,100 km, on the other side the river is borderd by forest and mountains and is why this way would be the main route for Lao migrant workers going to Thailand. All of these issues cause difficulty for migration control. In conclusion, we could say that Lao illegal workers use these ways for crossing the border. There are many Lao laborers who have steady relationships with Thai people by blood relations for example, or through marriage. In some cases migrants are using unofficial transactions to cross the border to Thailand for job opportunities. The majority of them are not aware of the official documents, or lack knowledge about travelling documents owing to fact they are too young and inexperienced.

According to the interviews made with village heads, and with the head of the families of illegal workers we could divide the migrants into 3 groups:

First Group:

This group have had relatives who are living in northeast Thailand since the pre-colonial period. These people will cross the border to Thailand after they have just finished their harvests in the rice field. They also return home during the productive season (always going back and forth). Generally, people have nothing to do while waiting for the productive season of harvesting rice and after harvesting. At the same time, in the village there are fewer jobs available for villagers. Many families had gone with their entire family to work; some of them had gone by themselves[8].

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[6] The speech of representative from the Department of Employment, Ministry of Labor and Social Welfare of Thailand at the meeting on 01-03 October 2004 in Chiangmai.

[7] From Thai authorities, Ministry of Labor of Thailand....

[8] The Key informant from Department of Labor, Ministry of Labor and Social Welfare of Lao PDR, and Lao employees of the cookie factory, garment factory and plastic factory at the Bangkok, Thailand on 16-21 June 2004

These people have legal or illegal documents, namely: passport, border pass or simple traveling papers made by the brokers or agencies for traveling, in addition they have gotten information before they leave to Thailand, or they have known where they should go to work before traveling. In other words, they usually received information in advance. In some cases they have to pay for a traveling fee and for other expenses to the broker with different prices, depending on the nature of the work and the place where they will go, for example: if someone would like to go to Southern Thailand they have to pay 6,000 Baht to broker; if they would like to go to Bangkok or XiengMai they have to pay 3,000 Baht; and to work in Isane (Northwestern Thailand) they have to pay 2,000 Baht per person. Informal networks have evolved in some areas but in some cases job recruitment through the illegal network is still not a guarantee of good pay and good working conditions. In many aspects the relatives remain silent when illegal workers are staying with them in the family.[9].

People who have gone to work mainly used the border pass as a travel document or have crossed the border with no permit. On arrival they have relatives or friends come to pick them up and guarantee them or hide them from migration authorities' control.

Second Group:

They have friends, or relatives who are working there before, and persuade them to migrate. This group uses passports with tourist visas for 3 months or border passes to enter into Thailand legally. In addition, they are looking for jobs and they have gone to work without legal registrations or permission, but are working and living illegally for 3 to 4 years[10].

Third Group:

This group have been persuaded by brokers with the cooperation of some local people to process the travel documents, border passes or passports. They have to pay the broker, for travel and other expenses. This group and their families do not have any information about work in Thailand.

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[9] Ministry of Labor and Social welfare, book …, 2004.

[10] The Key informant from Department of Labor, Ministry of Labor and Social Welfare of Lao PDR, and Lao employees of the cookie factory, garment factory and plastic factory at the Bangkok, Thailand on 16-21 June 2004

With the exception of the three groups mentioned above there were some people who voluntarily go, because of the need of their families, and have the comparison with their neighbors who had came back home, and have money to buy necessary goods for their family[11].

1. The main factors influencing Lao migrant workers going to Thailand.

According to Lee (1966), there are two main factors (push and pull) influencing migration from origin to destination areas. People decide to move for many reasons such as looking for work, to study, to work and so on. In Laos, two factors attractive to people moving from one place to others places in the country and cross border migration are as follow. Referring to the information from the case study we concluded that

Pushing factor: The fact of this situation occurs from the need of the family, and their poverty, unemployment, missing surplus income for their consumption, some families have a lot of children; for family survival children have to leave school and go to work in Thailand.

Pulling factor: Factors that attract or pull factor are because people have seen their relatives, friends, neighbors in the community who have gone to work in Thailand and brought money back home which could buy any [necessary?] goods like buying the motorcycle, small tractor, TV, mobile phone, build a new house or repair a house and so on. In other words, people have got information every day from TV, radio together with the propaganda of their friends; many of them know the owner of the factory and know the factory owner need the labor for their companies. All of these issues could push or pull them to work in Thailand.

According to the above mentioned issues we can define into 2 causes:

- **First cause** is the culture effect like: cultural festival, wedding ceremony, party and relative visit and so on.

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[11] source from Mr.Bounpheng, village head of BanePhai, head of family of BanPhai, Champone District, Savannakhet Province, 17/10/2004.

- **Second cause** is the economy like: looking for a job to earn more money, to save money for the family life. This is perhaps another cause why potential migrants are willing to take the risk of traveling to Thailand for job opportunities since labor conditions in big towns of Lao are still low by comparison and not enough developed.

Therefore the economic reason is one of the most important reasons for migrants[12]. However, at present in the Lao PDR there are many factories: small and middle size factories but most of those factories are situated in Vientiane which is becoming an attractive factor for people in the country side to migrate to Vientiane and to other big towns of Lao. This situation could increase the migration rate. The main groups of people are from Xiengkhouang and Huaphanh. People are not guaranteed find good jobs if they go to the big towns; the condition of the work may not be suitable for them; it is not like in Thailand. For these reasons people think that they rather go to Thailand than to Vientiane. However even though they already know about the disadvantages and high risk in Thailand, they still like to go there.[13]

In the Lao PDR, the provinces where there are more migrations to Thailand are: Bokeo, Xayabouly, Vientiane, Vientiane Capital, Borikhamxay, Khammoune, Savannakhet, Saravanh and Champassack[14].

Table 3: Occupation of Lao worker in Thailand

Activities	Number of Person	Females
Agriculture	3,993	1,363
Livestock	22,39	600
Minerals	16	9
Ceramic	160	38
Construction	1,389	144
Rice mill	100	31
Fishing in the sea	1,307	324
Deliver good in and from the stock	656	160
Housekeeper	12,676	11,647
Others sectors	19599	10,347

(Source: registration, 2002, Thailand).

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[12] Ministry of Labor and Social Welfare, Lao PDR, respond from official, and respond from Plastic, garments factories authorities Bangkok, Thailand.

[13] Ministry of Labor and Social welfare, Lao PDR, 2004, book.

[14] Report on Lao illegal migration in Thailand. N0 909/2003.

The information given from many Lao migrant workers in Thailand gives quiet a similar view, for example: before registration to be a migrant worker in Thailand, workers do not have the right to go out from the factories, because they are afraid of getting arrested and can be fined by Thai authorities. Furthermore there are many Thai employers who take this opportunity to force Lao workers by different ways such as: threatening, hitting, exploiting labor, forcing them to work more, otherwise the factories owners will inform the police officials to arrest them. In the past until now, Lao workers are still faced with this situation and can be found in many case like: Lao laborers have been oppressed, arrested, drug abused, die, and have lost limbs. Fortunately, some of them have been assisted by the community to survive and were sent back to their home town[15].

After the Thai government launched the policy for migrant workers in Thailand, they have allowed migrant workers to register legally including Lao workers, at Thai Ministry of Labor. These policies provide the right for migrant workers to work in Thailand as laborers; and the right to be protected while faced with trouble, disaster and other matters. Migrant worker could also get social welfare from Thai authorities such as helping them when necessary. Migrant workers could work on time in accordance with the rules and regulations of Thailand. It means that after work they could go any where, like going out to have dinner with friend at the restaurants, or could travel around the city and they have the right to do any thing with out the fear of being arrested. Furthermore, this policy will provide the right of migrant workers as Thai worker[16].

Lao migrant worker who are registered will receive payment of at least 113 baht per day or more than that. On average they will get payment for their wages about 3,000 baht per month, and not more than 10,000 baht per month. In conclusion we could see that the salary or wages of Lao labor in Thailand is lower than the lowest rate of Thai labor, it is not the same as the declaration of Thai government.[17]

Additionally, registered laborers can be given time for work and relaxation according to the Labor Law of Thailand. For Lao laborers who are registered will receive

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[15] Human trafficking, Ministry of Labor and Social welfare, Lao PDR, 2004, book

[16] ASEAN meting, discussion between Lao and Thai Ministry Labor, dated 10/05/2002

[17] ASEAN Ministry Meeting, 10/05/2004, Ministers of Ministry of Labor

protection from the Thai Ministry of Labor and Social welfare. They could be protected by law of Thailand; they have the right to rent a house, or could have private accommodation; some of them have social welfare, for example, while they are sick they could be looked after by their employers, or in some places while they go to the hospital the work unit will look after them, but for the charge of the hospital they have to pay for themselves. In some factories, companies or places workers could receive a treatment policy (30 baht for all disease). In many places employers assisted their workers due to the condition and the contract between employers and employees.

The employment in Thailand for Lao labor has some advantages as below: increase in the living condition, gaining labor skills, and generate income for the family, for themselves and for the country as well.

Contrarily, most Lao migrant workers in Thailand have made serious problems that have affected Lao communities. For example after they come back home they bring unpleasant customs and culture to the communities like the way of talking, dressing, bad behavior and brought contagious diseases to society such as: HIV/AIDS, etc.. Some families miss their main labor for rice production, some are divorced or separated, and some families have gone with their entire members (to work in Thailand). In conclusion, Lao migrant workers in Thailand have more disadvantages than advantages.[18]

There are many aspects and conditions for Lao workers who wish to work in Thailand particularly for whom limited information and knowledge on principles or regulations of the labor workers; therefore they should pay attention to the complications for Lao illegal workers. These conditions make them very confused, anguished and always afraid of being arrested and so on.[19]

Even though, the Thai and Lao governments have signed an agreement on the cooperation of labor exchange between the two countries, Lao laborers are not yet protected as they should be. On the other hand, Lao workers don't have permit documents for working in Thailand. That situation could also confuse Thai authorities to control the living situation of Lao workers.

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[18] Interviewed Mr.Bounpheng, village head Naphei, Champhone District, Savannakhet Province, dated 17/10/2004.).

According to the policy of Thailand, to solve the problem of Lao illegal labor the process of the implementation should be taken under the umbrella of the rule and regulation of Thailand; for the security of the job and to secure the social and living conditions of Lao people along the Mekong river border. To guarantee Lao labour to work in Thailand legally in the future the government of Lao PDR and Thailand will develop effectively bilateral corroboration on labour forces to change the states of labourers before sending by improving the capacities and labor skills of Lao workers, helping them to work legally. In order to protect and secure Lao workers in Thailand by law for example: to secure the right, the benefit, health, and security of Lao workers as well. Both sides should increase understanding and good relationship to implement the agreement on Thai-Lao labour which had been signed.

In the future, Lao-Thai government will cooperate to improve labor for both Lao and Thai. Lao authorities will arrange registration for Lao labor in Thailand, and will cooperate with the Ministry of Labor and Social welfare of Thailand to transform illegal labor in to legal labor for those who have registered and worked in Thailand already.; to identify Lao labor in Thailand before issuing temporary cards by looking at travel documents namely boarder passes, and passports. If some of them lose their travel documents, local authorities from the provinces, districts or villages where they are from in Laos will confirm details of these people by communicating with the team identifying nationality in Thailand. If some of them are holding Lao passports or legal travel documents, these people will receive temporary cards. If some of them are not holding legal travel documents or living in Thailand for a long time, but have no confirmation about their staying in Laos before they went to Thailand from provinces, districts or villages,they will be considered later. The team doing national identification consists of representatives from various ministries namely: Ministry of Foreign Affairs, Ministry of Public Security , Ministry of Labour and Social Welfare . The team working on issuing passports or border passes for temporary use by Lao illegal migration workers in Thailand, it is necessary to get help from concerned authorities to implement and help them in the collection of Lao migration data in Thailand. [20]

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[19] Source from officers of the Ministry of Labor and Social welfare of Lao, and workers at Desert Factory, Gartment Factoris, Plastic Factories in Bangkok Thailand, dated 16-21/2004.

[20] Minute of the meeting concern about the implementation of Memorandum of Understanding on the Cooperation of Employment by senior officer from Lao and Thai First time at the Ministry of Labor and Social welfare of Thailand, dated 22/4/2004, at Saam District, Province Sarabouly, Thailand.

1. Village Level

The village committee must collect data in their own area of responsibilities in order to report to the district authority. Data collection should include the number of laborers, female, male, children, number of returned workers, checking surnames or nicknames of returned workers , names of parents, and how many returned workers are registered in the village's family registration book. The village authorities have to issue the documents for their own villagers to identify their villagers who are living in the village and for the returned workers from Thailand. Returned workers show their identification to the head of the village. The head of the village will control and declare identification of returned workers that were issued during their stay in Thailand), then report to the district authority. After checking and identifying the workers village authorities could issue certification for them and report to district level.

2. District Level

District authorities have to check the documents reported from the village level to identify the documents. If information is suspected or unclear the authority must check the family registration book of the village to make sure. After that district authorities could sign that document and report to provincial level.

3. Provincial Level

The provincial authorities should verify the reported documents submitted from district level and save that in the computer to send that data to central level: Ministry of Labor and Social welfare, Ministry of Foreign Affaire, Ministry of Interior, Lao Embassy in Bangkok or give to the mission team who will go to identify the nationality of workers, then the mission will issue temporary passports for Lao workers.

2. Study on Working situation and consequences of Lao migrant workers in Thailand

2.1 Case Study of NongBeukTay Village, Sikhottabong District, Capital of Vientiane

Village Background (general situation).

a. Land area: Nong Beuktay village has a total land area of about 173 ha.

b. Population: The original people of NongBeuk village are from Isan (Northwestern) , part of Thailand. At present there are 242 families and 232 households wherein the total population is 1195 persons, including 600 women. All of them are Lao Loum and they respect Buddhism. The most popular festivasl of the village are BounPhavet, BounKaophansa and the rocket festival. The number of young people is 341 persons of which there are 168 women. The main occupations of people are farmers (194 families), and other occupations such as retail traders (19 families), public worker (20 families). There is a handicraft sector such as blacksmiths, who make materials and equipment for agriculture production work and others. With referrence to the statistic in 2003, NongBeuk village had 6 rich families, 222 economically sufficient families and 4 poor families.

Basic Infrastructure of the village:

1. There is one road through the village which was co-funded by villagers and government: villagers 30% and government 70%. In addition there is a main road through the village in the north.
2. In this village there has been electricity since 1987.
3. 80% of the villagers have their own well water …
4. There is a small market located in the north of the village about 500 m.
5. One primary school and one secondary school (G^1 and G^2).

Working Situation in Thailand.

NongBeuktay village is one of the most popular villages of Sikottabong district, have been working in Thailand. [UNCLEAR]The numbers of villagers working in Thailand are 26 persons including 23 women. Of which 19 persons work legally and 7 persons are illegally working, including 2 men. The average age of the workers is 16-17 years old, and there are also some 40 years old persons who are the least educated. Their main jobs are as housekeepers, and agricultural workers such as rice cultivation, factory workers, and pagoda services.

Remittance: Migrant workers in this village have sent remittance to their families depending on their income, the average is 1000 B/ month, in some cases 3000/3 months, 7000 B/ 6 months or year

The reasons why villagers of NongBeuktay village go to work in Thailand are:

1. They have had relatives living there for a long time.
2. Difficulty in getting a job in Vientiane.
3. The wages are higher than in Vientiane.
4. Similar language and culture, and easy to communicate. Moreover, this village has a long Mekong border and it is easy to cross to Thailand.

The problems of migrant workers (NongBeuktay village) are:

1. Villagers don't have enough money to pay (for registration fee) to process the documentation fee or passport both on the Lao and Thailand side. The registration fee is for those who have the documents for visit or tourist (visa+passport), this is not the registration for working, but when they arrived there, they have the chance or ability to get a job.

2. Villagers have a high risk for illegal working in Thailand; they could be fined by Thai or Lao authority (they were fined by the lao authority: if they stayed up to 6 months = 200,000 kips, and below 3 months = 100,000 kips)

Therefore, the difficulties mentioned above are the factors of the labor development market. On the other hand, the relationship between villagers of NongBeuktay village and their relatives have decreased day by day because, their grandparents are getting older and dying. Consequently, the trend of worker migration to Thailand will gradually decline[21] because the wage is gradually increasing and there are more job opportunities, the education has been developed and the relationship between the relative of each others have declined since the older generation has passed away.

2.2 Case Stady of DonKhouang Village, NongBok District, Khammouane Province

Village Background (general situation)

a). Land Area: DonKhounag village has a total land area of about 120 ha

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[21] Interviewed Mr.Khonesavanh Thongdy, village head, NongBeuk village, Mr.Khampheng Sengmany, Deputy village head NongBeukTay village, Mr.Phoulatsamy, Head of Group village Security, date 5/9/2004.

b). Population: Original villagers total approximately 1301 persons, (643 females in 2004; there are 237 families and 230 households. Most people respect Buddhism. The most popular annual festival is Bounbeukphanek, usually organized after Lao New Year (during May every year). These villagers are composed of various mass organizations namely: Elderly Unit, Party Organization Unit, Youth Organization Union and Lao Woman Union. The main occupations of people are farmers (90% of the total population), in addition people have surplus jobs such as weaving, gardening (growing vegetables) and raising livestock etc .

Basic Infrastructure of the Village

1). Four school buildings which are comprised of a primary schools, secondary school and Upper secondary school. These schools were funded by government and the villagers.

2). Electricity since 1991

3). All villagers use well water and water pumps

4). There is one main road past the village which is co-funded by villagers and District Administration.

Working Situation in Thailand

The numbers of villagers working in Thailand is 96 persons which covers 7.3% of total population including 35 women, of which some people are under 15 years old and went to Thailand with their families or parents. The main jobs of Lao migrant workers in Thailand are: construction workers, agriculture workers (Durian and Rambutan fruit gardens) in Chanttabury Province in the East of Thailand.

The reasons why villagers of DoneKhouang village go to work in Thailand are because after finishing their harvest in the rice fields they are free, therefore they need to have the surplus income. On the other hand it is easy to cross the Mekong River, easy to communicate because of similar culture and language, lifestyle and the surrounding environment as well. These migrant workers cross the Mekong to Thailand by small boat and most of them are not officially permitted by Lao and Thai authorities. Because the process of legal documentation is quite complicated, expensive and takes time, for that reason the migrant workers are illegal. They go by groups but there are a few families who go by themselves. The period of time they stay there, is only three months per year.

The Consequences of Lao migrant workers in Thailand (DonKhouang villagers)

Since the past until now, Lao migrant workers have been increasing in Thailand, however in the future the trend of migrants would decline, because the policy of our government is to promote income activities as well as providing more job opportunities at the local levels. Nevertheless, migrants could earn some money for the livelihood of their families for instance building new houses or repairing houses, buying agricultural equipment as well as consumer goods for the household and others. Besides that, the worst effects from migration to the migrants themselves and also to the society are: drug abuse, unpleasant culture (unneat dressing, red hair, etc.). Although, the migrant workers have faced serious problems for example were exploited and oppressed by employers (unpaid wages, forced to be arrested, overwork but low wages). In addition, they could be fined by Thai and Lao authorities during travelling back and forth because both authorities don't promote illegal workers.

The rule of the village authority is to fine illegal workers: the first mistake can be fined 20,000 kips per person per time; the second time 50,000 kips; the third time 100,000 kips and the fourth 450, 000 kips.

Finally, the interviewees said that the trend of migrants to Thailand will be continuing for a while. Given that the job supply in Lao is increasing then DonKhouang villagers would not go to work in Thailand again.

Additionally, the groups of interviewees have raised the following suggestions:

a. Promote the micro finance (credit) to villagers for commercial production.
b. provide more job opportunity
c. Campaign and educate illegal migrants who don't have any benefits for themselves and others.
d. Reduce the risk of migrants, and have a legal process for their traveling and working.

2.3 Case Study of Nakham village, NongBok District, Khammouane Province

Village Background (general situation)

a). Land Area: Nakham village has a total land area of about 200 ha.

b). Population: The total population is approximately 1,779 persons, (911 females). The number of household are 316.. The main occupation of people is farming which covers 100% of the total population. They also grow vegetables, and raise livestock. Besides that many of them are retail traders, about 30 families. In the village people respect Buddhism and there is one pagoda. The annual festival is Bounphaveth. These villagers participate in different mass organizations namely: Elderly Unit, Party Organization Unit, Youth Organization Union and Lao Woman Union.

Basic Infrastructure of the Village:

This village is composed of:

1). One primary school (G1 to G5) which was co-funded by government (province 13 million kips) and villagers and some amounts contributed from Lao people abroad.

2). One Health Center and Traditional Medical Herb Centre.

3). Electricity since 1991

4). All villagers use well water and pump water

5). One main road passes the village

Working Situation in Thailand

The numbers of these villagers who have worked in Thailand are not regular, because in some years the number of workers increased and in some years decreased. Those migrants have gone to work repeatedly. Therefore, the authorities don't know the exact number of migrant workers. For the year 2004, the numbers of migrant workers were 231 persons which covered 12.9% of the total population of the village, wherein the age group 15-45 years old covered 90%, and for the age lower than 15 years old covered 10%.

Villagers of Nakham village worked in Thailand because they are unemployed after harvesting in the rice field (during the non productive period). Of the other reasons it is easy to cross the Mekong River, easy to communicate, similar culture and language, similar lifestyle and surrounding environment as well. On the other hand, villagers couldn't sell their products; people need the surplus income to spend for their families. Their main jobs are: construction workers, and housekeepers for women. The areas where they work are: Rayong Province, Chanthabouly Province, Samui Island and Phouketh Province. Mostly they had gone to Thailand by small boat illegally, in which only 2 % have officiall

permits (permit for visit and short stay but not permit for working). They had gone by group for a period of more than five months, every time. While working they have faced serious problems for example were oppressed by employers (unpaid wages, forced them to be arrested, gave them a lot of work to do but paid low wages). In addition, they could be fined by Thai authorities before they travel back home.

The Consequences of Lao migrant workers in Thailand (for Nakham villagers)

The interviewees had reported that working in Thailand has some benefits for themselves and for society for example: After work they have money for building or repairing houses, buying some motorbikes, or equipments including consumer goods for households, some time they could contribute to social activities. Furthermore, they can gain labor skills e.g. can build the school; construct the houses and others to their village. Anyway, they have the worst effects from migration to themselves and also to the society for example: drug abuse, unpleasant culture (unneat dressing, hair coloring, etc.).

To reduce the number of illegal migrant workers to Thailand, the groups of interviewees have emphasized and suggested following:

a). Provide education to improve villagers, particularly for the young people, because most of them finished only upper secondary school.

b). Provide more job opportunities to villagers.

c). Reduce the risk of migrants by issuing legal documents for their traveling and working.

2.4 Case Study of NateuyNeua Village, Champhone District, Savannakhet Province

Village Background (general situation)

Nateuyneua village originally had the name Nolpapao village. This village was established by Grand Father Kousapho Phophan who came from Isan, Northwestern of Thailand. Nateuyneua Village is under the supervision of Champhon District, Savannakhet Province, which shares the border with Xiengbang village to the North, Nateuyntai to the East, Hommala village to the South and road number 13 south to the West.

a). Land Area: Nateuyneua Village has a total land area of about 500 ha.

b). Population: In fact, those villagers are native people, with a total population of around 1,493 persons, wherein 745 persons are female, and there are 235 households. The

main occupations of the people are farmers which covers 100% of the total population. The second occupation is growing vegetables particularly chilly, handicraft (making sweeper). This village has one pagoda and most people respect Buddhism. Bounphaveth is an annual festival for the villagers. In the village people are involved in different mass organizations namely: Elderly Unit, Party Organization Unit, Youth Organization Union and Lao Woman Union.

Basic Infrastructure of the Village

In the village there are:

1). Three Primary schools (G1 to G5), (in the academic year 2003-2004 there are 500 students)

2). One Health Center.

3). Electricity since 2000

4). All villagers use pumped water

5). There is one main road passing through the village

Working Situation in Thailand

The numbers of Nateuyneua villagers who are employed in Thailand are 200 persons which covers 13.3% of the total population. The main employment is working in the conserve factory, garment factory worker, cookie factory worker, plastic factory workers and others. Those workers are working in Bangkok. The reasons why villagers of Nateuyneua village go to work in Thailand is because they were persuaded by those who had gone before. Villagers cross the Mekong River by small boat, and use tourist passports for traveling which are valid for one year and can be extended two or three times. Each working period is two to three months.

The Consequences of Lao migrant workers in Thailand (Nateuyneua villagers)

The group of the interviewees gave the following views: there are some advantages for themselves, for families and for society for example: building or repairing houses, buying some motorbikes, small tractor, and equipments including consumer goods for households, contributing to social activities. At the same time there are disadvantages, for instance broken famililies, drug abuse, unpleasant culture (style of dressing, hair color, etc.). In some case they worked for only entertainment, consequently families have more debts. In addition they have had accidents for example the machine cut their hands (it

happened in 1994, a worker become handicapped). They also can be fined by the police officers during their travels[22].

Finally, the interviewees said that at present NateuyNeua villagers are not needed to go to work in Thailand because the villagers have enough production areas; particularly they can grow chilly for the market. In order to generate income for families, therefore, the groups of interviewees have highlighted and proposed the following:

a). to reduce the number of illegal migrant workers going to Thailand we should promote villagers to grow the chilly for commercial purposes.

b). to promote handicrafts appropriate to the potential of the village.

c). to promote agricultural production by rehabilitation of small scale and irrigation systems.

2.5 Case Study of Phai Village, Champhone District, Savannakhet Province.

Village Background (general situation)

Phoumlamnao village was the original name of Phai village. The name of Phai village is from the location of the village which has a small stream passing through it and is surrounded by bamboo trees. This village was established by Grand Father Kousapho Phophan who came from Isan, Northwestern of Thailand. Phai Village is managed by Champhon District, Savannakhet Province, which shares the border with Nakhoo village to the North, Khouakad village to the East, Nateuy village to the West, and Nasanh to the South.

a). Land Area: Phai Village has a total land area of about 900 ha.

b). Population: These villagers are the original inhabitants, with a total population of approximately 2,075 persons, (1,056 females), 335 households and 406 families. Actually, this village has a self-sufficient economy, only 5 families are not yet self-sufficient which covers 1.2% of the total population. The main occupations of these people are farmers which covers 100% of the population. Their second occupation is growing vegetables particularly chilly, watermelon, and livestock rising. This village has one pagoda which is called “Rerouvanh” and most people respect Buddhism. Bounphaveth is an annual festival for the villagers. These villages are involved in different mass organizations namely: Elderly Unit, Party Organization Unit, Youth Organization and

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[22] Interviewed Mr.Bounlam village head NateuiNua village, Mr.Bounehang First Deputy village head, Mr.Soukhane Second Deputy village head , Mr.Ouane,Head of Elderly Unit, Mr.Phouang village security NateuiNeua village, date 17/10/2004.

Lao Woman Union. Educational achievement of the village is that this village had eradicated illiteracy since 1993.

Basic Infrastructure of the Village

In the village have:

1). Primary school, class 5 only (this school was funded by Phai villagers living in the USA).

2.) One Health Center and Traditional Medical Herb Center.

3). Use electricity since 1999

4). All villagers use well water and pump water

5). There is one main road passing through the village

Working Situation in Thailand

Phai villagers working in Thailand is about 250 persons. Female labor are working as housekeepers, for males occupations are: construction workers, factories workers, iron factory. The reason why people in Phei village had gone to work in Thailand is they have been persuaded by their friends in the same village. Especially they have gone since 1975 to Bangkok (in the area of Yaovarath, Bangphakeo, Bangbone, Hualanphong.). They used tourist passports for traveling. When the police control they show their labor card that employers issued for them. The trend of Lao workers migrating is practically increasing (on average 1 person per family).

The consequences of Lao migrant workers in Thailand (for Phai villagers)

The interviewees: there are some advantages for example they could have money for repairing a house, and have gained the labor skills (this group has some little skill). Some of them could read and write the Thai language. However, there are some disadvantages for example drug abuse, contagious diseases, and the death of 2 persons (father and son), some families have broken (married with new wife in Thailand), the style of living of the family had changed in to the worst way. In addition villagers have had accidents and 1 person died (Mr. Khaoune), in some cases Lao brokers brought them to the factory and took forward their wages, so that workers could not get a salary for the first month. Their work and their salary is not fair. That is why some workers have to escape

from the factory, and also while they cross the border the Thai broker are also took money from them[23].

Finally, the interviewees said that they don't want villagers go to work in Thailand any more, because the profit they had got is less than the loss or disadvantages. On the other hand the living condition in Laos is better now than before. Once again the interviewees propose that the village should promote more job opportunities for villagers.

3. The Situation of the families left behind in Laos

According to interviews in five villages, there are 30 heads of households who have family members or children working in Thailand or who returned home. The total population is 205 people. Most of them are agriculture families 100%, LaoLum and Buddhist. The maximum number of family members is 13, the minimum is 2 and the mean is 6-7 persons. The family size of migrant workers containing 5-6-7 persons has a higher rate of migration than those with 2 and 13 members. According to the observation, the small family size does not like to move out of family because they may have enough consumption for living (for a few persons) they do not want to leave their house and members to live and work alone. And it is very interesting, the outcome of big families migrants also moves less than others, the reason is those families have enough land for their agriculture and all members have an occupation. Therefore, percent of big families there have a member moved very low. And the other words, there are only a very few family have a member move to work in Thailand as show on the chart below.

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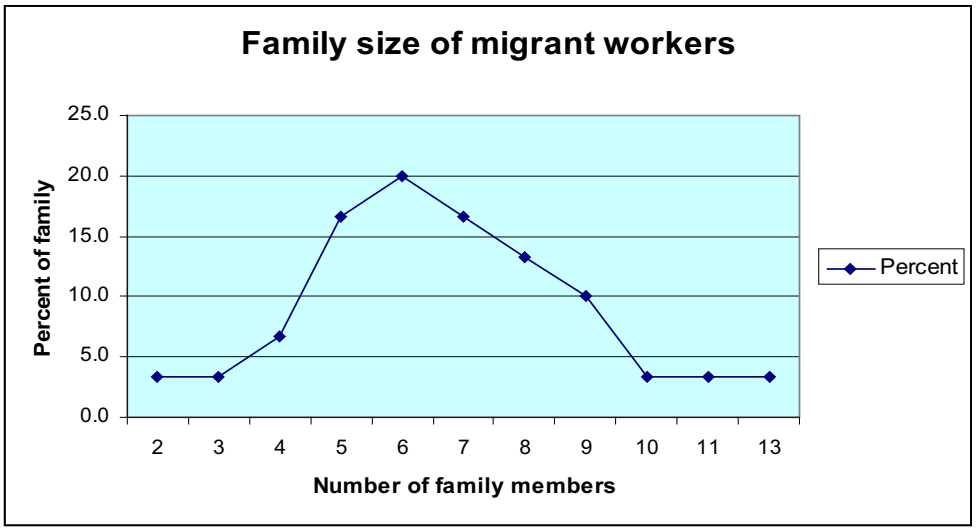
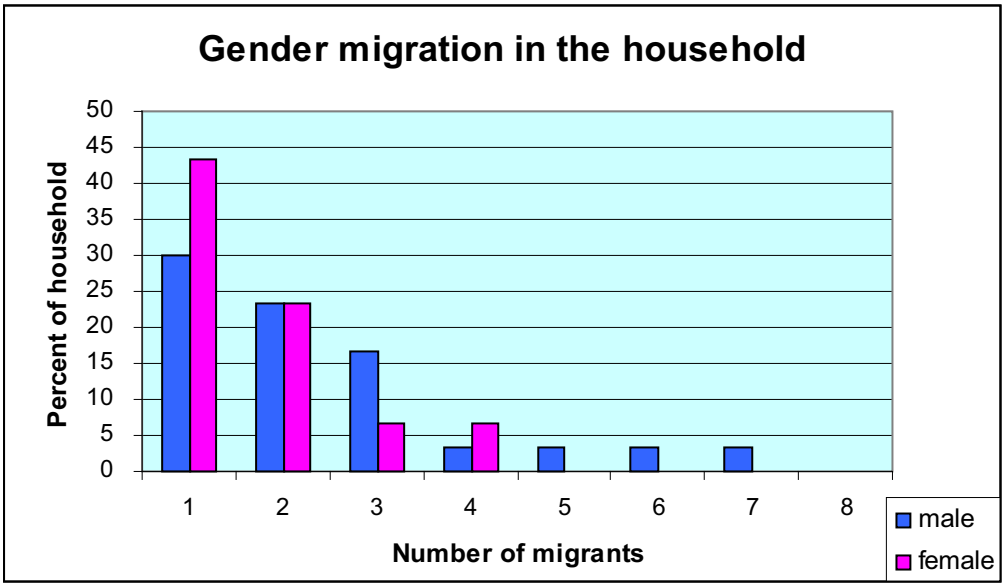
[23] Interviewed at Bane Phai, date 17/10/2004, Mr.Bounpheng , village Head of Phai village,and Mr.Sisavanh, Deputy village Head.



Refer to the household interview, the total number of population is 203 there are 101 migrant workers working in Thailand (50 % of family members), 60% are male and 40% are female. They are documented migrants 13,3% and undocumented migrants 86,7%. In the case study, at the present Lao migrant workers working in Thailand for more than five months are 93% and less than five months are 6,6%. Those who migrated to Thailand by group is 50% of migrant households, those who went alone 36,7% and migrated all family member and seasonal migration 13,3% as below.

Type of migration	**Percent (%)**
Go alone	36,7
Go by group	50
All family member	6,7
Seasonal migration	6,6
Total	100

Percent of household who has family member migrated one person is quite high in which female migration rate is higher than male. Follow by households have two migrants, the migration rate of male and female are the same. However, the male migration rate of households have three migrants is high double of female. Conversely the female migration rate of households have four migrants is high double of male. And percent of households who have five, six and seven migrants is low and have only male migrants



The reason for moving, we can conclude that the involuntary migration is about 33,33%, due to the culture and language is quite similar so that migrants can communicate and go easily is 26,66%, unemployment 13,33% and 10% lack of agriculture land.

Reason of moving	**Percent (%)**
Lack of agriculture land (farm land)	10.00
Not enough productive land (garden)	6.67
Unemployment (no job)	13.33
Be persuaded and propaganda by brokers	6.67
Be encouraged by parents	3.33
Involuntary migration (go unwillingly)	33.33
Easy to Communicate and go (due to the culture and language is quite similar)	26.66
Total	100.00

Positive consequences

The fact and process of leaving are usually products of conditions and exigencies in the source communities and the impact of migration on source communities are linked to the experiences of those who have left. Furthermore, the purpose of migration- and of staying away often evolves and changes over time. In order to understand the impacts of migration on those left behind we need not only to consider the process of leaving, but also the process of returning

Family improvement: While Lao migrant workers are working in Thailand they have sent remittances to their parents each year or 2-3 time per year for family living, this is to improve the family condition. Percent of families have been improved better condition is 76,7% and they use amount of money from remittance to:

- build new houses or repaired houses 46,7%
- save money for family living and sister or brother education 6,7%
- reduce the remaining debt 6,7%
- buy domestic materials, small tractor or motorbike 26,7%
- buy new land (building land or farm land) 6,7%
- improve family relationships and have better living condition 10%

In addition, when they come to visit home they bought electricity material (appliances), clothes, and automobiles for their families.

Remittance: Remittance is an important factor leading to an increase in living standards and directly affects household income and indirectly affects health and modifies health of the left behind. Mediators that connect remittances to improved health of people in the communities left behind include "improvement in food habits, nutritional status and health seeking behavior" (Hadi 1999:2), Despite the usually found positive impacts of remittances, some studies found only little, no impact, or even negative impacts of remittances on 'the left behind' and sending communities.

According to interviews 80% of families have received remittances from their family members working in Thailand and 20 % have never received the remittance from their children. The detailed information is as follow:

Unit in Baht / per year	Percent (%)
<5000	10.0
5000-10000	13.3
10000-20000	13.3
20000-30000	20.0
30000-40000	6.7
>40000	16.7
Total	80.0
No remittance	20.0
Total	100.0

Income: The deficiencies of seeing migration as a straight product of economic differentials are clear. At its most simple, the poorest villages in Laos do not have the highest level of mobility and the poorest households are not more likely to engage in migration than the less poor. Looking at the household income classification of migrants it seems to be poor households 13,3%, those have incomes low than 100000. And families have high income from 1000000 to more than 3000000 kip is quite high 53,34% of households. It means that more than half of migrant's families in the case study are not poor, they may have a source income from their agriculture production or livestock, remittance and so on. Some of household income has been improved after their children or a family member has gone to work in Thailand because they sent money to help their families for investment in their own business and agriculture work. The percentage of income classification is not a big difference and is as follows:

Household income (kip)	Percent
<100000	13.33
100000-500000	16.67
500000-1000000	16.67
1000000-1500000	16.67
1500000-2000000	6.67
2500000-3000000	13.33
>3000000	16.67
Total	100.00

Compare with Thai Baht (265 kip = 1 Baht)

Negative Consequences

Referring to the household interview and 5 focus group discussion interviews in five villages, we conclude that there are 20% of parents who do not know of any problem which is happening with their children in Thailand at the present. The following households, 40% their family members have no problem while they are working in Thailand and 40% have many problems, the details of the problems are shown in the table below.

Current Problems of migrant workers in Thailand	Percent
Do not know what happened with the children	20.00
Seem to have no problem with their children	40.00
Their children work hard and get low salary	6.67
Almost 10 years, did not get any information	3.33
Hired work and illegal work, they are unhappy	10.00
Married with Thai men (sometimes has problem)	3.33
Be afraid to be arrested (no registration)	3.33
Employer didn't pay salary, inform to the polices	6.67
Complicated registration	3.33
Sometimes be sick, can not work, Emp. scold them	3.33
Total	100

The Consequences of migration for their families

As mention above, there are not all migrants could earn some money for the livelihood of their families for instance building new houses or repairing houses, buying agricultural equipment as well as consumer goods for the household and others. Some of them could earn money only for themselves. These make their family condition have some negative consequences as follow:

- Families shortage labour for agriculture sectors
- Husband and wife separated or divorced after returning
- Left their children with parents
- Only the old people stayed at home and work hard in the farm

Besides that, the worst effects from migration to the migrants themselves and also to the society are: drug abuse, unpleasant culture (unneat dressing, red hair, etc.)

4. Response

4.1 At the Central Level

The source of revenue of people would be the most important issue for the government, especially the resettlement of Lao workers who have been working abroad. At present, there are more Lao workers in Thailand than in other countries. In the past, the government has made the effort to negotiate with the Thai government in order to resolve the problems

that occurred with Lao workers in Thailand, and has made the effort to foster the quality of life of all people.

- Presently, the government has been implementing the socio economic development program in rural areas for example: building up the infrastructures like schools, providing teachers, promoting local people to be able to access information, public services, health services (establish village health care service), construct roads, extend electricity networks, install water and sanitation facilities, birth spacing project, family planning and others. (that can slow down the increase of population and lead to a better quality of life)
- The Foreign investment promotion policy of the government helps to improve the socio economic situation and generates income for people and provides more job opportunities to young people. Promote commercial production for export [incomplete sentence]. In addiction the government has provided educational services on health care services; the use of new technology in production; environmental protection and natural resource conservation.
- The Government has the project to promote culture and tradition of villagers, for example project of village culture.
- At the ministry level such as the Ministry of Foreign Affairs, the Ministry of Labor and Social Welfare and the Ministry of Interior all together have negotiated and discussed with the Thai government many times to solve the problem of Lao migrant workers in Thailand.

4.2 Local Level

Local authorities have responded with implementation of the party policy on socio-economic development. In the past local authorities at the provincial level, district level and village level have shown their responsibilities on enhancing the quality of life of people at their own scope, including the migrant workers' family. The main tasks are:

- Realize the plan of action of the government on fostering the quality of life of people from the centre to local level and
- Report the achievement process concerning the living of people and the circumstances of Lao migrant workers to the government at the central level to help solve the problems that occur.

- Set up the mission to local areas and awareness of people to know the disadvantages of migrant workers in Thailand.
- Educate villagers and enforce migrant workers who have brought unpleasant culture to local people.
- Security protection to facilitate local people in term of development and spend lives peacefully and securely.

4.3 Mass Organizations

The mass organizations such as youth organization, women union, and syndicate organization have also responded to help government on the implementation of the party policy: educate people to know the advantages and disadvantages of migration in Thailand. Their activities are as below:

- Educate members of the youth organization and the public to understand the best things and worst things of migration. Help stabilize society and jointly develop the country together with government organizations.
- Look for funding resources and establish income generation for villagers. For example help people to plant vegetables, animal farming and handicraft production.
- Develop skilled labor, set up sport associations, culture and others social activities.

4.4 International Agencies and Non Governmental Organizations

The government budget normally is not adequate for the socio economic development program. NGOs come to have a role to help the government on development. The tasks of NGOs are as follows: help government to build infrastructure such as build schools, provide education, promote in preserving culture, provide health services, technical support, training, workshops, constructing roads, and help Lao migrant workers who are seriously exploited from employers abroad.

5. Recommendations

5.1 To central level:

- As we know that the Lao PDR is located in the middle of the Mekong sub-region and has become the transfer point of migrant workers. Due to this situation we would propose to the government to implement measurements, methods, rules and regulations concerning migration in order to protect the effect from migration in the short and long term.
- The Lao PDR is a member of ASEAN, in the future Laos will open free trade with ASEAN and there will be no visa requirements for entering and departure among ASEAN countries . At this time Lao skilled workers might go out of the country for higher wages. At the same time Laos could be faced with a lack of skilled labor. For these reasons, the government should have a plan to collaborate with ASEAN countries within the ASEAN framework on labor or adopt /accept the convention on migrants' labor protection.
- To prevent the problems of Lao migrant workers in Thailand, Lao authorities should cooperate and negotiate with Thai authorities again at all levels to help solve the problems occurring with Lao migrant workers, for example:
  - Thai employers exploition of the labor force of Lao migrant workers.
  - Workers have been oppressed and abused (physically, mentally, and sexually) in many aspects.
  - Illegal migrant workers and so on.
- The socio-economic development programme of the Lao PDR should make achievements especially in rural areas namely providing education, improve technical knowledge; educate villagers and build up income generation for rural persons in order to have a better quality of life. It is the way to reduce the number of migrant workers to Thailand.
- Migrant worker identification and issuing work permit to them to send them to work with agreement made between the Lao and Thai governments.

5.2 To local level

- Local authorities should train and educate villagers to know the advantages and disadvantages of migrant workers in Thailand by collaborating with mass organizations.

- Provide suitable infrastructure for rural people such as: public services, education, health care, support for local people and provide sustainable livelihood.
- Restrict the behavior and punish the persons who entice migrants, particularly young people and girls, into forced labour and sex work with lies and false promises.

5.3 To mass organizations

- Mass organizations especially the Lao youth organization should educate their members and all youth to be aware of the social injustices that have occurred to them.
- Increasing the job opportunities for young people and public services to generate job opportunities by supporting many vocational training methods.
- Find ways to attract young people by promoting domestic products, advertising, awareness campaign and encourage them to be proud of their own culture in order to reduce mistreatment by persons who would take advantage of them and put them at risk.
- Provide educational services to young people to escape from HIV/AIDS, drug addiction and also educate them to know how to protect themselves from these problems.

5.4 For International agencies and NGOs:

- Increasing assistance to the Lao government for socio-economic development particularly in remote areas, supporting the needs for socio-economic development such as materials and equipment, provide grant aid for villagers in order to raise the living conditions of people in the country side, and improve the quality of life of the rural villagers.
- The neighboring countries, developed countries, international organizations and NGOs should continue to assist and cooperate with the Lao government to solve the problems occurring with Lao migrant workers in Thailand.

6. Conclusions

The geographical situation of Lao People's Democratic Republic is provides the context for migrant workers to both immigrate and emigrate and is a transfer point.

Therefore, in the past the Lao PDR was faced with the problem of migration. The main issues of Lao migrant workers are as below:

1. The majority of Lao migrant workers are in Thailand. They have low labor skills and therefore their wages are very low. They mainly work in the agricultural sector, service sector, and some work in the small industry sector. Moreover, they don't have official documents; just a few numbers of persons have official permits to work.
2. The main factors that forced/push migrants to go to work are: similarity of culture and language, low income, low education, smuggling, propaganda and their innocence or vulnerability. On the one hand, they need to earn the surplus money after working in the rice field; the demand of consumer goods has increased, and they would like to try their luck to know modernization abroad.
3. The factors that attracted/pulled them are: high wages and salary in Thailand; there a lot of job opportunities, and they are made curios by his propaganda, and the advertisements.
4. The fate of Lao migrant workers is not the same for everyone, some of them could be successful but they are less in number, some fail with bad fortune and become desperate, some have died or gone missing.
5. Local authorities and families are not promoting them to go to work but some families think that it is necessary to work for the families' survival or some want the experience.
6. The consequences of migration are both positive and negative. The positive consequences are that migrant workers may bring money to their families; some of them may gain labor skills which they could use in their village when they return home, and make family life better (especially for those who have relatives in Thailand who give them some security when they are working in Thailand). The negative consequences are caused by lack of labor force at home, some have got contagious diseases, some families have broken down and divorced and some of them have brought unpleasant style of life in to their home town.
7. The Lao and Thai governments and concerned agencies have made the great effort to resolve the problems of migrant workers in many ways. The result of this effort could reduce the trouble of migrants step by step.
8. The number of the migrant workers at present is stable but in the future the number of legal migrants could increase because of the policy of cooperation

between both governments who should work together to reduce the number of illegal workers.

9. In terms of these issues above, all parties in the society including government, public and private sectors, local authorities, mass organizations, and NGOs etc… should have responsibility to solve these issues in the short term as well as the long term.

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Labor Migration and Rights-based Issues in the Greater Mekong Sub-region: Documented and Undocumented Women Migrant Labor from Burma, Cambodia, and Lao PDR in Thailand

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Abstract:

The paper examines numbers of documented migrants from the three countries and provides estimates the actual numbers of migrants, with the ultimate goal to identify rights-based issues faced by them and how to mitigate violations of their rights. It focuses on women migrant labor in domestic work. The methods used are literature review and interview with a number of women migrants. The Burmese are the majority of migrants, followed by the Cambodian and the Laotian. They usually entered Thailand by means of smuggling ring. Some women migrants were physically and/or sexually abused by either Thai smugglers or smugglers of their own national and have no means to file complaints. Despite their work permits, some Thai officers have exploited them through extortion and confiscation of their documents. Most employers of foreign domestic workers pay them lower wages than their Thai counterpart, and abuse them in various manners. Some female domestic workers get married to the male from their own country of origin, but lack contraceptive knowledge, leading to unwanted pregnancy, illegal abortion or unwanted births. Language barrier discourages both documented and undocumented female migrants from accessing public health services. Domestic workers are in the informal sector and are "invisible workers". Foreign domestic workers are not only unseen but also subjected to potentially higher level of abuses. Attempts to legalize migrants, including women migrants in domestic work, have not been very successful. As human beings and as women, they should know and be able to exercise their human rights, women's rights and rights of migrant workers. Multi-sectoral, multi-stakeholders approach, keeping in mind rights-based framework, should be taken to devise some effective legal mechanisms to protect and promote their rights.

1. Background

In the rapid process of globalization, transborder migration becomes a common phenomenon. Before the 1980s, Thailand was a labor sending country, but since then, it has become both sending and receiving country. Just before the economic crisis in 1997, the Royal Thai Government (RTG) became concerned about the large illegal inflow of migrants from neighboring countries and from some South Asia, who were illegally employed.

The first attempt to regulate and control the illegal migration and employment was made in September 1996. The RTG, through the Ministry of Labor (MOL), allowed illegal migrant workers from Myanmar, Cambodia, and Lao PDR to temporarily stay and work by means of registering them and provide them with work permits. There have been registrations in subsequent years, the latest one of which was in 2004. The registration fees are to be borne by the migrants. The wide economic disparity between Thailand and the neighboring countries makes it inevitable that migrants consider the registration fees to be very high and are disinclined to register. No one knows for certain the number of undocumented migrant workers.

The Department of Employment of the Ministry of Labor (MOL) reported that 288,780 transborder illegal migrants registered and were granted temporary stay and work permits in Thailand in **2003**. An MOL official estimated that there were another 800,000 unregistered immigrants from the three countries, resulting in the estimate total of 1,088,780.[1]

The official primary data as of May **2005** on documented migrants after the July 2004 registration are in Appendix 1 (Demand, Quota and Work Permits Issued to

[1] Sontisakyothin, Sakdina 2004 "Labor Movements in Thailand: Principle Challenges and the Three Pillars Management Solution." Paper presented at the Regional Workshop on Managing Public Goods: Health, Labor Mobility, Water, and the Environment. June 28- July 2. Jointly organized by Singapore' Ministry of Foreign Affairs and the ADB. Singapore

Migrants from Myanmar, Lao, PDR and Cambodia).[2] The total demand was for 1,598,752 migrant labor, and the given total quota was for 1,512,587 laborers. However, the actual work permits issued totaled 846,568. Of the total, 631,386 (75%) were Burmese, 105,156 (12%) were Laotian and 110,026 (13%) were Cambodian. In the category 10 "Household Domestic Workers", the total demand was 178,588, the quota given was 169,754 and the total actual permits issued were 126,325. Of the category 10 permits, 85,954 (68%) were issued to the Burmese, 32,113 (25%) to the Laotians and 8,258 (7%) to the Cambodians. It should be noted that these figures are primary, not yet finalized. The total demand and the work permits issued differs by only 52,263, but through interviews with migrants, actual number of all domestic workers is here believed to at least double the number of work permits. In 2001, 14.5 percent of all work permits were issued to domestic workers [3], which amounts to around 82,400 under the assumption that most domestic workers are female. Punpuing, et. al. [4] believe that the 82,400 registered migrants represented only one-third of the total domestic workers and provide a conservative estimate of over one hundred thousand migrant domestic workers. When applied their estimate and the interviewed migrants' estimate to the 126,325 registered domestic workers, the estimate is between 250,000-380,000 total migrant domestic workers by the end of 2004.

2. The Status of Domestic Work in Thailand

The RTG considers domestic work as informal sector employment. As such, domestic workers are deprived of the labor rights and protection as stipulated in the Thai labor law.[5] Women migrants in domestic work have quadruple status as human being, women, workers and migrants. Rights-based framework of gender sensitive analysis requires that relevant international treaties be used as the standards whereby violations of rights are identified and rectified. Before examining relevant

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[2] Office of Foreign Workers Administration, Department of Employment, Ministry of Labor

[3] Archavanitkul, Kritaya. 2003 Status of Knowledge on Immigrant Labor in Thailand and Research Directions to be Considered. (in Thai) p.32, Table 6, footnote F. NakornPrathom: Population and Social Research Institute, Mahidol University

[4] Punpuing, Sureeporn., Caouette, Therese., Pasam, Awatsaya and Khaing Mar Kyaw Zaw "Migrant Domestic Workers: From Burma to Thailand, p.2 Footnote 9

[5] c.f. Korsieporn, K. 2005 "Women's Rights in Relation to Employment in the Context of Thailand's Open Market Economy." Paper presented at the Regional Consultation on Economic Rights of Women

international treaties, the number of women migrant workers and of migrant workers in domestic work will be provided, followed by instances of rights violations of women migrants in domestic work.

3. Number of Sex-desegregated Migrant Workers

Dr. Kritaya Archavanitkul [6] provided estimates of sex desegregated data up to the year 2001 and the Office of Foreign Labor Administration [7] provided the data from 2002 to 2004, as follows:

Table 1 Sex desegregation estimates by country of origin, 1998-2004

	Burmese		Cambodians		Laotians		Total	
Year	Male	Female	Male	Female	Male	Female	Male	Female
1998	53,387 (68%)	25,670 (32%)	9,716 (92%)	877 (8%)	1,029 (82%)	232 (18%)	64,132 (71%)	26,779 (29%)
1999	59,968 (67%)	29,350 (33%)	8,418 (89%)	1,074 (11%)	849 (73%)	315 (27%)	69,235 (69%)	30,739 (31%)
2000	58,701 (65%)	32,023 (35%)	6,898 (87%)	1,023 (13%)	749 (74%)	262 (26%)	66,348 (67%)	33,308 (33%)
2001	257,354 (57%)	193,981 (43%)	43,216 (75%)	14,340 (25%)	25,771 (43%)	33,587 (57%)	326,341 (57%)	241,908 (43%)
2002	192,169 (57%)	147,860 (43%)	28,149 (76%)	8,669 (24%)	13,166 (40%)	19,326 (60%)	233,484 (57%)	175,855 (43%)
2003	134,812 (54%)	112,979 (46%)	13,976 (71%)	5,699 (29%)	8,611 (40%)	12,703 (60%)	157,399 (55%)	131,381 (45%)
2004	350,401 (55%)	282,053 (45%)	77,238 (70%)	32,804 (30%)	47,315 (45%)	57,819 (55%)	474,954 (56%)	372,676 (44%)

Source: 1. Archavanitkul, K. Status of Knowledge on Immigrant Labor in Thailand and Research Direction to be Considered. (in Thai) March B.E. 2546 (2003) Population and Social Research Institute, Mahidol University: NakornPrathom p. 33
2. Office of Foreign Workers Administration, Department of Employment, Ministry of Labor (Mimeo.)

There is a perceptible trend toward annual fluctuation in the percentage of female migrants by nationality. For example, from 2000 to 2004, Burmese women migrant workers with work permits comprise the great majority of all documented women

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(CEDAW Article 11 & 14), organized by the International Women's Rights Action Watch Asia Pacific (IWRAW Asia-Pacific) and Lao Women's Union. Vientiane, Lao PDR. May 15-18

[6] Op.cit. Archavanitkul ,Table 7, p. 33

[7] I would like to thank Dr. Prakai Kithikun and her assistant, who kindly contacted the Office of Foreign Workers Administration, Department of Employment, Ministry of Labor, on my behalf.

migrant workers, namely, 96%, 80%, 84%, 86% and 76%, respectively. These percentage declines are undoubtedly due to the increase in women migrants from the other two nationalities. However, it is strongly believed here that the Burmese are more visible and more likely to be abused, even if they have work permits. Thus, Burmese women migrants, especially those in domestic work, are less likely to have work permits for the reasons, which would become obvious in later Section of this paper.

Most Thai people would assume that Thai domestic workers are female. Statistics from the Office of Foreign Workers Administration show that in the case of migrant workers in domestic work, there are both women and men, though migrant men engaged in this occupation in much lower proportion than the women counterpart. Table 2 shows the number and percentage of male and female migrants in domestic work from the year 2001 to 2004.

Table 2 Sex desegregation estimates of domestic workers by country of origin, 2001-2004

Year	Burmese		Cambodians		Laotians		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
2001	6,786 (11%)	54,595 (89%)	1,076 (26%)	3,104 (74%)	1,521 (9%)	15,307 (91%)	9,383 (11%)	73,006 (89%)
2002	6,761 (14%)	43,282 (86%)	530 (16%)	2,725 (84%)	1,128 (9%)	10,935 (91%)	8,419 (13%)	56,942 (87%)
2003	6,730 (16%)	34,179 (84%)	459 (18%)	2,052 (82%)	1,156 (12%)	8,109 (88%)	8,345 (16%)	44,340 (84%)
2004	12,898 (15%)	73,073 (85%)	1,860 (23%)	6,398 (77%)	4,046 (13%)	28,068 (87%)	18,804 (15%)	107,539 (85%)

Source: Office of Foreign Workers Administration, Department of Employment, Ministry of Labor

It is noticeable that the registration rates of all migrant workers in the years 2003 and 2003 are low and are reflected in the subset “domestic workers”. It would be useful to delve into factors accounting for this phenomenon, if the RTG’s goal is to reduce the number of undocumented migrant workers.

To examine the proportion of documented women migrant workers who are in domestic work, Table 3 is here presented.

Table 3 Women migrants in domestic work compared to all registered women migrants, 2001-2004

Year	Burmese		Cambodian		Laotian		Total	
	DW*	Total	DW*	Total	DW*	Total	DW*	Total
2001	54,595 (28%)	193,981 (100%)	3,104 (22%)	14,340 (100%)	15,307 (46%)	33,587 (100%)	73,006 (30%)	241,908 (100%)
2002	43,282 (29%)	147,860 (100%)	2,725 (31%)	8,669 (100%)	10,935 (57%)	19,326 (100%)	56,942 (32%)	175,855 (100%)
2003	34,179 (30%)	112,979 (100%)	2,052 (36%)	5,699 (100%)	8,109 (64%)	12,703 (100%)	44,340 (34%)	131,381 (100%)
2004	73,073 (26%)	282,053 (100%)	6,398 (20%)	32,804 (100%)	28,068 (49%)	57,819 (100%)	107,539 (29%)	372,676 (100%)

Note: 1. * DW = Domestic Workers
2. This table is calculated from Table 1 and 2.

The percentages in Table 3 can be interpreted in a number of ways:

1. Women migrants in domestic work comprise roughly one third of all women migrant workers because by nature, it is demeaning and demanding, though not so dirty and dangerous.

2. On average, over 50 percent of Laotian women migrants are domestic workers most likely because there is hardly any language barrier or any cultural barriers compared to the Burmese and the Cambodian counterparts.

3. The decreasing percentages of domestic workers from the 2001-2003 period compared to the year 2004 may be due to the fact that, through social networks developed over the years in Thailand, they change to other occupations where their rights are less likely to be violated.

4. Pertaining to the Burmese, they have a public park as their meeting place where women and men from the same tribe meet on their New Year Day (Thai's Songkran Day). Many but not exactly known number of women domestic workers form serious relationship with men from the same or similar tribes (e.g. Pa-o tribe and Karen tribe), get de facto married and move out of domestic work.

4. Violations of Women Migrants as Migrants and as Domestic Workers

4.1 Recruitment and Immediate Pre-departure

1. Exorbitant fee demanded by recruiters

   Burmese recruiters at present demand about 10,000- 20,000 baht (about USD 250-500, Kyat 210,000-420,000 [8], or Kyat 222,000-444,000 at Mae Sot in May 2005 [9]).

   Ma Khin May (aged 18, interviewed in 2005): "My family is very poor because my father deserted us to have a new wife and never sends us money. We don't have any paddy land; only the land where the house is. In 2001, my mother had to borrow 800,000 kyat from a local moneylender to pay the recruiter to take my younger sister and me to Bangkok. Just after our New Year, my mother called me up and asked me to send money home to pay the moneylender. Now, the debt has accumulated so much because of the high interest rates. As I cannot save any money, I told my younger sister who is a domestic worker to send it instead."

4.2 In Transit

1. Physical abuses

   Tida (aged 23, interviewed in 2004): "In 2000, about 20 of us from my village were put in a pick-up truck. The truck was rebuilt such that 10 could lay cramped on the truck floor and the rest on the above floorboard. The recruiters did not divide one floor for girls and another for boys; we somehow had to squeeze in the available space. Then the truck was covered by canvas and it was very hot and difficult to breathe. We traveled

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[8] www.dft.moc.go.th. Calculated from USD 1=Kyat 850 as of March 2004 (black market rate).

[9] Actual rate is Kyat 100 = 4.50 baht as of May 2005, at Mae Sot and Myawaddy.

the whole night and were close to the Mae Sot border. We were put in a small shelter house and were given some food and water. There was no privacy, but a lot of mosquitoes. After two days, we traveled cross the Thai border with a Burmese and a Thai recruiter. We stayed in a house in Mae Sot and waited to be taken to employers."

4.3 On Site

1. No information by smugglers/recruiters on actual occupation and destination

   Tida (aged 23, interviewed in 2004): "I told the recruiters in 2000 that I want to work in Bangkok, but they drove me and several other girls from Mae Sot to a place I didn't know. I found out later that it is a province called Loburi. I worked with two other Burmese girls in a bakery shop and then a friend of the shop owner, who was looking for a domestic worker, asked the shop owner to find her one. She and her husband picked me up in a car and this was how I became a domestic worker in Bangkok."

2. Lack of sufficiently detail information from the RTG

   This situation of men migrants exemplifies that faced by women migrants.

   Ma Mek (38, 2005): "I didn't know that we were prohibited to leave our provincial areas; registration officers did not inform us. They just told us that if we change job, we had to notify the district officers. I was just going to see my wife. I was so worried about her and the baby."[10]

3. Extortion by both Thai smugglers and police officers

   Thai TV Channel 9 reported on 29th May 2005 that a group of about 15 Burmese were being smuggled into Bangkok. The smugglers' pick-up truck had an accident. The investigation revealed that the smugglers demand 800 baht from each Burmese woman and 1,500 baht from each Burmese man to smuggle them from Nakornsawan to Bangkok. According to Sangsit Piriyarangsan (May 2005), Thai police officers' earnings from

[10] www.jrs.net/reports/report.php?lang=es&repld=th050214en

the non-formal sector of the economy includes that from the migrant labor. The estimate amounts to 1,800 million baht in 2004.[11]

Da Moh (16, 2005): "It was about a year ago, during April 2004, my brother, his girl friend and I went to Central PhraRam 3. While I was waiting for them, a policeman asked to see my work permit. He was going to take me away someplace, but my brother came back in time and gave him 200 baht. That policeman gave me back my work permit."

Ma Aye (20, 2004): "One afternoon I was going to a bank to transfer 6,000 baht to my middleman to have it sent to my family back in Myawaddy, a policeman stopped me and asked to see my work permit. He then inspected my shoulder bag and took away the 6,000 baht. It was my three months' wages as a domestic worker."

4. Low wages, overwork and no holiday

   Wages of domestic workers range from about 500 baht/month in Mae Sot to about 2,000-3,500 baht/month in Bangkok. Thai national who are willing to do domestic work demand about 5,000 baht/month. Despite the wage difference for the same type of work, both foreign and Thai domestic workers have to work long hours without fixed period of work and no holiday. Some fortunate ones are allowed to go out for a day to celebrate Songkran holiday.

5. Employers' refusal to registration

   Aye (15, 2005): "My employer is a prosecuting attorney and his wife is a housewife who sometimes goes away to sell jewelry. They have two young children. They employ a Burmese as a domestic worker and me as children caretaker. They registered the domestic worker, but do not register me. I don't really know why."

6. Bad working conditions

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[11] "Estimate of Informal Sector Economy: Illegal Income of Policemen in B.E. 2546 (2003)" in *Matichon Weekly*. 20-26 May B.E. 2548, p.80. Reproduced from "Policemen, Corruption and Thailand" in *Thai Post*, 13 May B.E. 2548

TidaTue (16, 2005): "I worked in a Chinese shop-house. There were two other domestic workers from Lao. They slept in a double-decked bed, because they were hired before me. I had to sleep on cold cement floor and was very cold and uncomfortable. I asked the lady employer for a mat, but she never got around to give me one."

7. Lack of freedom of association and movement

   Aye (15, 2005): "My employer locks me, the other Burmese and his two children in the house all day during his work days, maybe because my employer doesn't register me and because he works for the Thai government, he doesn't want anybody to know that he employs me illegally."

   Ma Kyi Oo (25, 1999): "Akhin and I worked for a family consisting of six adults and four children. They didn't like us to have any contacts with outsiders including our agent. We were so tired of not having Burmese friends and felt so very isolated that we contacted a Burmese student who visited us at our workplace. It was unfortunate that the male employer came back to the house at that time and found out. Everyday after that, they got a member of the family to come home to check us out and by the end of that month, we were paid our wages and told to leave the house immediately."[12]

8. Appropriation of Work Permits

   Ma Aa Cham (16, 2005): "Both of my employers are civil servants and have to be away all work days. They are afraid that I would run away to get a better job if I have my work permit. They took away my work permit and gave me a photocopy to carry with me when I run errands for them. When they let me go to the Park to celebrate our New Year, my friends who also are domestic workers told me their employers did the same thing. A friend who has been in Bangkok for over ten years told us that

[12] Excerpt from Kertmongkon, Adisorn (editor) June 2003 Life Story of Burmese Labor: From Slave Labor to Illegal Labor. Fuangfah Printing, Ltd.: Thai Action Committee for Democracy in Burma (TACDB), pp. 108-110

photocopied work permits are not recognized as legal documents, but I don't dare to ask my employers for my real work permit."

9. Physical, sexual and psychological abuses

Ma Shwe (28, 1999): "There were four members in the family of my employer, but the first son was in the U.S. The female employer was very cruel. Whenever we did some work incorrectly, she would punish us. Sometimes when we didn't understand the Thai language she spoke, she would hurt us anywhere in the house with anything close at hand. Sometimes, she hit us with a broom and she often scraped my throat with a cutter. My left eyebrow had a swollen cut because she hit me with a broom. I decided to run away from the house after she slapped my face with a slipper." [13]

Mu Mu (16, 2004): "My agent was an Indian Burmese. He took other Burmese and me from Mae Sot to a house in Bangkok and promised to take me to work in a restaurant. One day, I thought he was taking me to a restaurant, but he took me to a hotel. He raped me for three nights and locked me up in the hotel room while he worked during the day. After that he bought me a blouse and a pair of pants and took me to work in a snooker club. There were a lot of men there, to whom I had to serve food. There was a small space in the kitchen for me to sleep, but I was so afraid and sad that I ran away to seek help from a Burmese nearby. She managed to get me two jobs as domestic worker with good employers, but I couldn't stay and kept crying when I thought about what the Indian agent did to me."

Michu (19, 2004): When she was 14, Michu got a job through an agent to work as a domestic worker for a family that ran a small restaurant in Northern Thailand. The wife managed the restaurant while the husband had a job elsewhere. He later lost his job and often stayed at home playing with their child. At around the age of 16, the husband bought her clothes and Michu understood that she faced implicit sexual demands from him. She did not dare to stop him and had to have sexual relationship with him.

[13] Ibid., pp.105-106

He later became ill and the wife asked her to look after him, who eventually died. Michu was informed at his funeral that he died of AIDS. She was afraid neither to go for an HIV test nor to tell the wife. She was healthy up to that point, but found out that she was HIV+ and died a year later.[14]

ILO News (Released 4 May 2005): … 17-year-old Burmese Karen girl was working in the home of her Thai employer at the time of the attack. She received severe injuries, including a fractured skull and a shattered ribcage. The girl remained in hospital for two months and needed several operations including one to insert a metal plate in her skull. Her employer, a 32-year-old Thai woman, has been charged with the assault. She has denied all charges and has been released on bail.[15]

10. Economic exploitation

Ma Shwe (28, 1999): "An agent named Ashar took Chit Bu and me to Bangkok since 1995. The employer too us to his house in Samrong Tai. I didn't how much money the agent took from the employer, but we were never paid during the four years we worked there." [16]

Mu Mu (16, 2004): " I worked in the snooker club for 15 days, with the employer's promise of 3,000 baht per month. As I didn't have enough clothes, he bought me some that cost 700 baht. I thought he gave it to me for free, but when I left and asked for part of my wage, he refused to pay me, saying that he already advanced my wage in buying me the clothes. I think even with the 700 baht's deduction, I should be paid 800 baht."

ILO News (Released 4 May 2005): "The teenage victim told a news conference in Bangkok that her family had paid 12,000 baht (USD 300) to an employment broker who found her the job. She alleged she had been confined to a residence, suffered systematic physical abuse and had not received any of her agreed 4,000 baht monthly salary (USD 100)"[17]

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[14] Toyata, Mika. "Health Concerns of 'Invisible' Foreign Domestic Maids in Thailand.", p.10 in www.populationasia.org/Publications/RP/AMCRP19.pdf
[15] www.ilo/public/english/region/ASRO/bangkok/child/trafficing/downloads/ilocdwstatement.pdf
[16] op.cit. Kertmongkon, Adisorn, p.105
[17] Ibid.

11. No reproductive health right

A case study by Toyota [18] related a story of a Burmese girl named "*Mio"*, who worked as a domestic worker for 18 years. She was brought to a family that involved in border trade when she was nine years' old. She helped with the household choirs and keeping the inventories of the stock of goods in exchange for food, shelter and some occasional money. When she was 16, she was brought to Chiangmai to work as a shopkeeper for another family that is related to the first family. She was wooed by a Burmese and later became pregnant by him. The employers were displeased and offered to take her for an abortion. Being 27 years' old by then, Mio decided not to undergo an abortion out of fear and of the fact that it might be her last chance to have a baby. Not taking the offer, she had to leave the employment.

12. Dismissal without due payment

Michu (19, 2004): After the female employer's husband died of AIDS, she gave Michu 50,000 baht (USD 1,204) as the accumulated five-year's wages.[19]

13. Racial and ethnic discrimination

"Kim" [20] (22, 2005): "Most employers of Burmese domestic workers believe that they are selfish, disloyal, stealthy and untrustworthy. For example, they would ask for their wage and sometimes borrow an amount of money and promised to return to work after visiting their family in Myanmar. Most of them never return. My friend's mother in Mae Sot doesn't have a domestic worker, but declined to hire a Burmese for fear that she might steal or hurt her and her family."

[18] op.cit.,Toyata, Mika., P.13 (excerpt)
[19] ibid.
[20] A reliable Thai informant, whose family has a business in Mae Sot.

4.4 Return

1. Appropriation of cash and belongings

   Ma Kye (20, 2005): "When I visit my mother to give her money and other things, I have to be smart enough not to get them confiscated by the Burmese soldiers. Last time, I wanted to take her a tiffin carrier, I had to fill each container with cooked rice and food. When the soldiers saw that the rice and food had gone sour, they wouldn't take the tiffin carrier."

2. Ridicules and discrimination by fellow villagers

   Dao (16, 2005): "My friends who came to Bangkok at the same time as I did can save money to send home, have their houses built and have gold earrings and necklace. I was stolen 2,100 baht and my brother keeps asking me for some money and never returns them. I can save any money. Now that I am a domestic worker and don't have to pay for room and food, I will save every baht until I have enough to get the things my friends have already had before I dare to return home. I will be too ashamed to return now."

   She Hare (17, 2004): "I met my husband to be at a New Year celebration day and got married to him six month after. When I told him I was pregnant, he left me. I had an illegal abortion for 2000 baht or I would be gossiped about as a bad girl, as I would have a baby without any husband."

5. Relevant Major International Treaties

There are several international treaties pertinent to women migrants as domestic workers. Some articles in each treaty are more relevant than other ones. This paper refers only to the most relevant treaties and articles. Though each treaty gives different emphasis to certain rights, several treaties can be applied to protect an individual's rights. The treaty most directed toward migrant workers is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. UNESCO's summary of issues with the identification of articles is in this text, but the details of the mentioned articles are in www.ohchr.org.

5.1 UN Universal Declaration of Human Rights (1948)

Article 23

(1) Everyone has the rights to work, to free choice of employment, to just and favorable conditions of work and to protection against employment.

(2) Everyone, without any discrimination, has the right for equal way for equal work.

(3) Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holiday with pay.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

5.2 Convention on the Discrimination of All Forms of Discrimination against Women (CEDAW)

Article 11 (1, f) and (2, a, d)

1. State Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on the basis of equality of men and women, the same rights, in particular:

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discriminations in dismissals on the basis of marital status;

(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

Article 12

1. State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning;

2. Notwithstanding the provisions of paragraph 1 of this article, State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

5.3 ILO International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

According to UNESCO, the Convention aims at guaranteeing equality of treatment and the same working conditions for migrants and nationals. UNESCO provides a summary of the issues and articles as follows:

- Preventing inhumane living and working conditions, physical and sexual abuse and degrading treatments (articles 10-11, 25, 54),
- Guaranteeing migrants' rights to freedom of thought, expression and religion (articles 12, 13),
- Guaranteeing migrants' access to information on their rights (articles 33, 37),
- Ensuring their right to legal equality, which implies that migrant workers are subjected to correct procedures, have access to interpreting services and are

not sentenced to disproportionate penalties such as expulsion (articles 16-20, 22),

- Guaranteeing migrants' equal access to educational and social services (articles 27, 28, 30, 43-45, 54)
- Ensuring that migrants have the right to participate in trade unions (articles 26, 40).

Other Articles pertinent to women migrants as domestic workers are:

- Article 14 (arbitrary interference with correspondence or other communications, or to unlawful attacks on his or her honor and reputation)
- Article 15 (expropriation of the assets of migrant workers)

5.4 Convention on the Right of the Child

Due to economic and/or political hardship in the countries of origin, many migrant workers had to register by giving the ages that are more than their actual ages. Women migrants in domestic work usually report that they are 18, when they might be 15. Thus for domestic workers who are actually younger than 18, this convention is in force. Many articles are relevant, the simplified version of which are here presented.[21]

- Article 6 The right to life;
- Article 15 The right to be with friends;
- Article 16 The right to a private life;
- Article 19 The right to be protected from being hurt or badly treated;
- Article 24 The right to good health and to medical care and to health care information;
- Article 34 The right to be protected from sexual abuse;
- Article 35 The right not to be kidnapped or sold;
- Article 36 The right to protection from any other kind of exploitation;
- Article 39 The right to help when having been hurt, neglected or badly treated.

[21] www.savethechildren.ca/resources/pdf/crc/pdf

6. Gender Sensitive Rights-based Framework

Women and men migrants are faced with different treatments. Considered as the weaker sex, they are more likely to face more problems and abuses. Their rights are more likely to be violated. To be gender sensitive, rights-based framework has to take into account the differences between gender roles, gender role expectations and differential treatments due to different gender roles. For examples, women migrants are seen as preferable choice as domestic workers. They, not men, are potentially faced with such problems as unwanted pregnancy, unsafe abortion, and sexual abuse by male employers.

7. Efforts to Mitigate the Violations

1. At international level

UNESCO advocates ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families by all states and disseminates information about this convention and other legal instruments concerning migrants through its website.

UNIFEM (Bangkok) runs a migration program that seeks to inform migrant women about their rights and help create legal, policy and institutional changes to the migration process in both sending and receiving countries. It also attempts to make "women in migration" another issue in the Beijing Platform of Action for women in development. This effort has resulted in the Working Meeting to Discuss the Content of CEDAW General Recommendations on Migration at Siam City Hotel, Bangkok during April 15th-16th, 2005. The CEDAW Committee Migration Task Force and UNIFEM were the organizers.

International Women's Rights Action Watch Asia Pacific (IWRAW Asia-Pacific) and Lao Women's Union of Lao, PDR jointly organized a Regional Consultation on Economic Rights of Women (CEDAW Article 11 & 14), one theme of which was international women migrant labor in the informal sector.

2. At national level

2.1 By the RTG

The RTG really does not have any policy on international migration of labor from Myanmar, Cambodia and Lao PDR, but has been attempting to rectify this by:

2.1.1 The RTG signed an MOU with each of the three countries of origin. The MOU with Myanmar was signed on 21 June 2003, with Cambodia on 31 May 2003 and with Lao, PDR on 18 October 2002.

2.1.2 The Department of Labor Administration under the auspice of the MOL set up the "Sub-committee on Systematization and Standard Setting for Employment of Foreign Migrant Workers". It comprises all relevant government agencies (about 15 agencies), two academic institutions, and three employer organizations (Fishery Association of Thailand, the Thai Chamber of Commerce and the Federation of Thai Industry). In the Thai labor context, the tri-partite system is used, having the government representatives, the employers' representatives and the employees' representatives. In the foreign labor context, the question is whether or not the foreign employees should be included and why.

2.2 By the NGOs in Thailand

Many NGOs in Thailand are concerned with the plights of migrant labor in Thailand, not very many are active due to the rather unfavorable attitude of the RTG toward NGOs. Here are some NGOs ' activities in assisting migrant labor.

Rakthai Foundation has been helping migrant workers in corporation with Ban Paew Hospital to educate Burmese fishermen on HIV/AIDS and its prevention, The Foundation has a clinic as well as mobile clinic to provide reproductive health services to Burmese women migrants.

Asia Pacific Forum on Women, Law and Development (APWLD) has the Labor and Migration Programme (L&M) that focuses on addressing the lack of legal protection and human rights standards for women migrant workers and those

employed under sub-standard working conditions.[22] Pertaining to domestic work, APWLD members and partners attempt to develop an acceptable working definition of "domestic work" with the goal that the RTG recognize domestic work as formal sector employment.

Migration Assistant Programme (MAP) has several programs:
Since September 1997

Health Project
Crisis Support project
Media Kit Project (Radio program and Material Production Program)
Community Education Project
Women Project called "Women Exchange" (WE)
Violence against Women Project

Coalition to Fight Against Child Exploitation (FACE), among other activities, attempts to get back wages for victims of trafficking and labor abuse.

8. Constraints to the Efforts to Reduce Rights Violations

8.1 The RTG's inability to hasten the process of setting an explicit policy on migrant labor, which accounts for political, legal, economic and humanitarian considerations to benefit the country in the long run;

8.2 The RTG's reluctance to sign the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, despite of the fact that Thai emigrant workers need protection and to have the rights in terms of remuneration, social welfare and other basic human rights;

8.3 In the case of women migrants in domestic work, the RTG does not recognize domestic work as work in the formal sector. It has critically negative impacts on domestic workers, particularly foreign domestic workers, because their rights are seriously and systematically abused without or with little outside help.

[22] www.apwld.org

8.4 The RTG fails in its “war against corruption”; bribes to and extortion by border police and police extortion are common and widespread.

8.5 Law enforcement is lenient toward employers and punishment of offenders is even more lenient if they are in the police force or Immigration Bureau.

8.6 The RTG’s relevant agencies fail to inform migrant labor of their rights and duties as well as failing to break the language barrier.

9. Recommendations to Alleviate Violation of Rights

1. Set up right-based immigration policy to deal with the issue of migrant workers.
2. Carefully consider if migrant workers have the right to be in the Sub-committee, as they are also a stakeholder. If not, should there be more representatives from academic institutions as they have no vested interests.
3. Improve the registration process in the mean time and reduce the fee to motivate undocumented migrant workers to register.
4. Ensure strategic policy planning and efficient and effective implementation.
5. Establish monitoring and evaluation system to check on implementation.
6. Devise and implement effective and impartial means to stop extortion and bribery.
7. Recognize domestic work as formal sector employment.
8. Provide more support to NGOs in their efforts to help migrant workers whose rights are abused.
9. Sign the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, with reservation as seen necessary.

Appendix 1 Demand, Quota and Work Permits Issued to Migrants from Myanmar, Lao, PDR and Cambodia, 2004

15 May 2004

Occupation	Activity											
	Demand for Labor Migrants				Quota				Work permits Issued			
	Total	Burmese	Laotian	Cambodian	Total	Burmese	Laotian	Cambodian	Total	Burmese	Laotian	Cambodian
Total	1,598,752	1,136,485	216,823	245,444	1,512,587	1,086,653	198,659	227,275	846,568	631,386	105,156	110,026
1. Fishery	127,796	75,162	4,767	47,867	124,210	72,795	4,604	46,811	60,598	34,653	2,702	23,243
1.1 Coastal	120,409	70,265	3,745	46,399	117,085	68,010	3,655	45,420	56,258	31,337	2,100	22,821
1.2 Freshwater	7,387	4,897	1,022	1,468	7,125	4,785	949	1,391	4,340	3,316	602	422
2. Occupations in consequence of fishery	130,935	119,372	3,549	8,014	129,765	118,399	3,473	7,893	74,234	68,588	1,062	4,584
3. Agriculture and livestock	380,488	269,344	44,636	66,508	361,318	263,298	39,114	58,906	182,698	145,047	17,107	20,544
3.1 Agriculture	330,978	233,291	35,662	62,025	316,536	228,474	33,463	54,599	156,472	125,274	13,473	17,725
3.2 Livestock	49,510	36,053	8,974	4,483	44,782	34,824	5,651	4,307	26,226	19,773	3,634	2,819
4. Rice mills	12,692	11,469	645	578	12,261	11,068	635	558	7,107	6,568	295	244
5. Brick-making factories	9,440	8,143	869	428	9,136	7,878	833	425	5,114	4,479	412	223
6. Ice factories	7,626	5,892	981	753	7,267	5,680	903	684	4,450	3,614	529	307
7. Water transport of goods	7,764	3,009	583	4,172	6,961	2,805	146	4,010	4,312	1,789	109	2,414
8. Construction	259,884	173,909	27,959	58,016	250,253	167,002	26,763	56,488	124,533	87,562	9,325	27,646
9. Mineral and stone mining	2,770	2,385	215	170	2,705	2,351	184	170	1,548	1,394	56	98
10. Household domestic work	178,588	120,991	45,357	12,240	169,754	114,292	44,099	11,363	126,325	85,954	32,113	8,258
11. Others (specify)	480,769	346,809	87,262	46,698	438,957	321,085	77,905	39,967	255,649	191,738	41,446	22,465

Note: The total number of demand includes the additional number that employers requested, according to the Cabinet's resolution of 14 September 2004

Conference on Transborder Issues in the Greater Mekong Sub-region
Borders and Health: A Study of Lao Patients Seeking Health Care in Thailand

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The research study presented is realized and financed within the framework of an International Volunteer in IRD (Institute of Research for Development) and more precisely in research unit 178 "Conditions and territories of emergence of diseases" directed by Jean Paul Gonzalez. The study is also part of a global research program led in Vientiane and called "Urbanization and spatial disparities of health in Vientiane".

INTRODUCTION

'To judge by tendencies shown in recent (in the last ten years) university geographical production, in time borders will cease to be seen as boundary lines and barriers. We affirm that they fulfil new functions, those of link and junction, so much so that they have become the base of original regional constructions[1].' Michel Foucher refers here to current regional groupings in progress around the world such as ASEAN, the European Union and Alena. These political constructions tend to link countries in the same economic, political and social dynamics as are illustrated in the objectives laid down by the ASEAN at the time of its introduction in 1976 : 'The aim of the Association is to accelerate economic growth, social progress and cultural development in the region through joint endeavours in the spirit of equality and partnership in order to strengthen the foundation for a prosperous and peaceful community of Southeast Asian nations, and to promote regional peace and stability […].[2]' The consequences of such regional movements have had a major impact on the perception and function of frontier spaces: long regarded as peripheral and decentred, these spaces are placed today at the heart of exchanges in an increasingly globalized economy.

In the Greater Mekong Sub-region, and more precisely between Thailand and Laos, the border became a dynamic area from the nineties onwards, with the economic reforms undertaken in Laos and in its opening to the outside. The construction of the Friendship Bridge between

[1] Foucher M. (1984). « Les géographes et les frontières ». *Hérodote* n°33-34, p.117-130. 'Si l'on en juge par les tendances récentes de la production géographique universitaire, depuis dix ans, l'époque serait, dit-on, à l'effacement des frontières comme lignes de séparation, comme barrières. On affirme qu'elles exercent de nouvelles fonctions, celle de trait d'union, de jonction, au point de devenir la base de constructions régionales originales.'
[2] ASEAN Website: http://www.aseansec.org/64.htm

Vientiane and Nongkaï in 1994 illustrates well the mutual wish to promote inter-state relations. It was followed by an increase in commercial exchanges and mobility, of many types, on both sides of the Mekong.

A certain number of research studies have already shown mobility and health links on this border; I think, for example, of the work undertaken by researchers[3] at the ARCM (Asian Research Centre for Migration, Chulalongkorn University, Bangkok) which attempted to study connections between the increase in transborder movements and the HIV/AIDS situation in the area.

The study that I propose to carry out also relates to the connections between mobility and health, but more precisely to the question of the health seeking behaviour of Lao people towards Thai health care infrastructures. Without being able to quantify these movements at the present time, it is clear that this phenomenon exists and that it is an important issue to analyse; the questions raised are numerous, including: What are the reasons for these health movements from Laos to Thailand? More precisely, what are the push factors in Laos which encourage patients to cross the border and the pull factors in Thailand which attract them there? Moreover we need to know how the movements are organised on both sides of the border. Are they individual or familial? What kinds of transportation are utilised to cross the bridge (car, bus, touk touk)?

Lastly, an interesting issue is what might be the consequences of these movements in terms of territorial re-composition. Are new spatial dynamics arising from the utilisation of Thai health care by the Lao population?

This article does not intend to present results nor make an analysis of data. It is rather a question of advancing research hypotheses and presenting the methods necessary to answer

[3] - Lyttleton C., Amornthip A. (2002). « Sister Cities and easy passage: HIV, mobility and economics of desire in a thai/Lao border zone », *in Social Science and Medicine Volume 54 Issue 4*, pp.

- Supang C., Amornthip A., Shati R. (2002). *Cross-Border Transportation Infrastructure Development and HIV/ Aids Vulnerability at Nongkai-Vientiane Friendship Bridge*, Asian Research Center for Migration, Chulalongkorn University (Study paper, Monograph???), 61p.

- Supang C. et al (2004). *Cross Border Migration between Thailand and Lao PDR : A Qualitative Assessment of Lao Migration and its Contribution to HIV Vulnerability*, The Asian Research Center for Migration, Chulalongkorn University, Executive Summary, 14p.

them, paying attention to the concepts of 'border' and 'geography of health' and the small amount of medical data available.

CONCEPTS OF FRONTIER

From the borderline to the interface: evolution of the object of Study

'Border' is a particularly polisemic word which indicates, in its simplest definition, 'the territorial limit of a State and its jurisdiction[4]'.
For a long time, the linear notion of frontier dominated geographic, cartographic and historic studies, which focused above all on the border 'line'; its course and its movement in military and nationalist contexts. Strongly associated with a function of rupture, Michel Foucher evokes 'the very widespread and mostly negative assessment of the border, whether familiar or remote. It connotes barrier and constraint, the arbitrary and the artificial, the colonial and the imperialist'[5].

But with the work of Ratzel[6], one of the founders of modern political geography, analysis of the border was gradually refined and asserted itself around the concept of frontier dynamics. Borders are no longer viewed as rigid and static lines of demarcation but rather as zones of confrontation, exchange and activity which make them geographical entities in constant evolution. Many geographers of the English[7] and French[8] schools considered, following Ratzel, that the 'zonality' of the border was a reality much more relevant than its linearity.

During the twentieth century, geographers thus renovated the notion of the border. The traditional concept of linear limits, more or less "tight" between states, evolved to the fuzzier but more fertile idea of frontier areas. The concept of border changed: it thickened, it took new significations, socially, culturally and economically. Unlike the border-as-rupture, this new concept privileged the border as a meeting point.

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[4] Brunet R. (1992). *Les mots de la géographie : dictionnaire critique*, RECLUS la Documentation française, 518p. 'La limite du territoire d'un Etat et de sa compétence territoriale'.
[5] Foucher Michel (1988). *Fronts et frontières. Un tour du monde géopolitique*, Paris, Fayard, 691p. 'L'appré ciation très répandue et le plus souvent négative de 'la' frontière en général, qu'elle soit familière ou lointaine Celle-ci connote la *barrière* et la *contrainte*, l'*arbitraire* et l'*artificiel*, le *colonial* et l'*impérialiste*.'
[6] Ratzel F. (1897 (ed. 1988). Géographie politique, Ed. régionales européennes, Genève, 385p.
[7] Fawcett C.B (1918). *Frontiers : A study in Political Geography*, Oxford.
[8] Vallaux C. (1911). *Le sol et l'Etat*, 363p.
Ancel Jacques (1938). *Géographie des frontières*, Paris, 52p.

Various and paradoxical frontier effects

Whatever it is, the border is a 'place of paradoxical relations' (Piermay[9]): it is at the same time cut and seam, danger and opportunity. In short, it produces, simultaneously, contrary effects.

At the junction of several states, trans-border areas are situated at the hinges of various political systems each of which model their national space in their own way. Distortions pass from one state to another in fields as varied as the economy, policy and jurisdiction. Even though tiny, these disparities create possibilities of play with the neighbouring otherness and allow opportunities for exchange, the driving role of the border which prevails over its role as brake.

Places of interface between several territories, frontier areas thus offer ideal terrain for exploiting gaps and existing differentials in the economic, lawful and demographic field... and thus to be able to trade.

LAO THAI CONTEXT

In the case of studied frontier space, we find again the paradox of the 'cut-seam' with on the one hand a past made of tensions and fights between the two countries and on the other hand, many unifying elements.

A rapport of secular strength

The relations between Laos and Thailand were for a long time characterised by conflict, arising from struggles over territorial questions. Qualified by Christian Taillard as a 'Buffer state[10]', Laos appeared for a long period as a Siamese dependency.

From 1700 Lao territory, because of its geographical and strategic position, was the centre of the territorial ambitions of Vietnam and Siam, causing its fragmentation into three kingdoms.

[9] Piermay J-L (1993). Citadins et quête du sol dans les villes d'Afrique centrale, thèse d'Etat, Université Paris X-Nanterre, Paris, L'Harmattan, coll. « Villes et entreprises », 579p. 'Lieu de relations paradoxales'.
[10] Taillard C. (1989). *Le Laos, stratégie d'un Etat-tampon*. Montpellier, GIP RECLUS, Montpellier, 200p.

‘In 1778 and 1828, the Kingdom of Siam twice seized the capital Vientiane, deported its population to the central plain and took control of the North East. Laos thus lost the right bank of the Mekong, where the vastest plains of the middle basin were to be found, and in consequence lost the majority of the Lao population. The river which had been an axis of gravity and a feature of union framing national space, then became a border that unbalanced and weakened the country[11].’ We thus passed from a space organized and populated around the Mekong to a truncated space, source of great difficulties for Laos.

The French colonial intervention in Laos put an end to the Thai territorial occupation. However, from the start of the twentieth century, Laos under French domination remained economically dependant on Siam. ‘All the imported products, except European consumer goods (clothing, provision, preserves....), come from Bangkok, and the products of High-Laos, Middle-Laos and even of the area of Bassac [Champassak], are exported by the natives to Bangkok[12].’

Throughout its history, Laos has preserved this dynamic of ‘Buffer State’, where unification is continually compromised and must always be rebuilt. Its geostrategic position gives it a function of hub where regional strategies are outlined and makes it a highly-coveted place. Thailand was always a powerful neighbour, influencing the course of Lao history, and we will see that still today the relations between the two countries are strong and specific.

Common Points

Despite the divergent factors which have appeared during the history of the two countries, many cultural, religious and linguistic elements engender a sense of great proximity between the societies of these close countries.

[11] Taillard C. (1989), ibid. p. 23. ‘En 1778 et 1828 le royaume de Siam s’empara à deux reprises de Vientiane la capitale et déporta sa population vers la plaine centrale et prit définitivement le Nord Est.. Le Laos fut ainsi amputé de la rive droite du Mékong, où se trouvaient les plus vastes plaines du bassin moyen et par suite de la majorité de la population lao. Son territoire se trouvait déséquilibré et fragilisé par le fleuve, devenu frontière alors qu’il était un axe de gravité et un trait d’union charpentant l’espace national.’

[12] Beau Paul (1908). Situation de l’Indochine de 1902 à 1907, rapport du Gouverneur Général, Marcellin Rey, Saïgon, p.360. ‘Tous les produits d’importation, sauf les produits de consommation européens (habillement, provision, conserves….), viennent de Bangkok, et les produits du Haut-Laos, du Moyen-Laos et même de la ré gion de Bassac [Champassak], sont exportés par les indigènes sur Bangkok.’

In spite of the border which separates Laos and Thailand, there is a strong ethnic continuity on both sides of Mekong. Indeed, following the plundering of Vientiane, a great number of the Lao ethnic group were displaced to the Thai side and thousands of families were thus divided. Today 'Lao are nine times more in Thailand (with 15 million Lao Issan in the North-East and 3.5 million Khon Muang in the North), than in Laos (where they represent only 1.8 of the 3.5 million inhabitants)'[13].

Moreover, from a linguistic point of view, Lao and Thai are from the same family of languages known as tai. This enables the populations to communicate easily, which contributes to facilitating exchanges and movements on both sides of Mekong and thus to bringing the two countries ever closer.

Present context: from signs of opening... to the projects of co-operation

From 1975 in SE Asia, the cold war era was marked by strong political oppositions and Laos found itself again at the crossroad of various influences. Although reunified, it was located at the break which separated Thailand from communist Indo-China. During this period, Laos withdrew and closed its borders.

Today the subsiding of world and regional antagonisms has allowed Laos, as in pre-colonial times, to develop again its position as intermediary and crossroad between Thailand, which tends to be the hegemonic economic power of the peninsula, China, whose commercial presence has strongly asserted itself and Vietnam.

To reach this situation, the opening of Laos has occurred in stages, beginning in 1979. There was an initial economic opening with the announced end of forced collectivisation in the countryside and the re-establishment of an open market for the sale of agricultural produce. The private commercial network was restored in parallel with the official network. In 1984, new measures of economic liberalization were taken to stimulate the country's production.

[13] Taillard C. (1989), ibid. p.20. 'les Lao sont neuf fois plus nombreux en Thaïlande, avec 15 millions de Lao Isan dans le Nord-est et 3,5 millions de Khon Muang dans le Nord, qu'au Laos où ils représentent seulement 1,8 des 3,5 millions d'habitants.'

'The effect of these measures didn't take long and between 1985 and 1986 exports from Thailand to Laos increased by 57%, imports by 18%[14].'

But the true turning point came in 1988 with a redefinition of regional strategies. After an armed clash in February that year, at the border with Sayaboury province, Laos and Thailand signed a cease-fire to begin a true policy of co-operation: the border was reopened at five points on the Mekong which became places of official exchanges.

With the opening of Laos at the end of the eighties, large scale co-operation projects were undertaken in order to create a more effective connection between the two countries more quickly. On 23rd April 1994, the Friendship Bridge connecting Nongkai to Vientiane was inaugurated: financed by the Australian government, it is the first direct link by road between Laos PDR and Thailand. Whereas before it took several hours to complete the customs administrative steps for travel by ferry, it today takes approximately 20 minutes to cross the border by the bridge. In April 2004, a daily shuttle (minibus) was founded to facilitate better the cross-border movements.

In the same spirit, in April 1997, the Lao and Thai authorities signed an agreement for the construction of a second bridge over the Mekong between Mukdahan and Savannakhet. Work began at the end of 2003 and the bridge will be put into service in few years.

Such infrastructures symbolise the permanent connection of the Lao network to that of its Thai neighbour, who wishes to increase trade in Southeast Asia.

Growth of exchanges and mobilities at the border

Mobility is a good indicator of the evolution of relations in a border area. In the case of our study on both sides of the Mekong and more specifically the Vientiane-Nongkai border area, transport was for a long time made by ferry and then by road thanks to the bridge which opened in 1993. According to the table in the following page, the bridge has played the part of accelerator of flows on both sides of the river and as the available sources in Thailand show, the traffic has multiplied by more than 5 times between 1992 and 1997.

[14] Taillard C. (1989). ibid, p.138. 'L'effet de ces mesures ne s'est pas fait attendre et les exportations thaï vers le Laos ont progressé de 57%, les importations de 18% entre 1985 et 1986'.

From the point of view of health movements

Concerning mobility of health, the work of Richard Pottier[15] shows that in 1973 the crossing of the Mekong to seek health care in Thailand was already an existing practice of people living in the border regions. This study focused on Tha Düa, a village along the Mekong, located approximately thirty kilometres from the centre of Vientiane.
Looking at the example of the health seeking behaviour of women in childbirth, the survey reveals that for women who had used a health care structure, 9.4% went to Thailand.

As regards the use of health resources in general, the survey shows that '43.7% of those who had a need for an unspecified treatment bought drugs either in the pharmacies of Vientiane, or (two times more) in those of Thailand. It should be noted that a quarter of the total number of sick people (119/476) and 30.6% of those who had recourse to a treatment, bought drugs in Thailand. The purchase of drugs in Thai pharmacies, in fact, represents the type of treatment generally used[16].'

Movement of vehicles on both sides of the border between Nongkai and Vientiane from 1992 to 1997

Type of vehicles	1992	1993	1994	1995	1996	1997
Cars	n.a	n.a	2 819	8 621	9 330	11 649
Pickup Truck	n.a	n.a	3 786	9 259	10 878	15 856
Bus	n.a	n.a	14 277	6 160	3 092	3 547
Trucks, vans	n.a	n.a	16 446	33 302	30 547	31 767
Total	**12 000**	**17 500**	**37 328**	**57 347**	**53 847**	**62 839**
Average/month	1 000	1 458	3 111	4 779	4 487	5 237
% change	--	+45,8%	+113,4%	+53,6%	-6,1%	+16,7%

Source: Department of traffic, Nongkai, Thailand.
n.a: not available.

[15] Pottier Richard (2004). Santé et Société au Laos (1973-1978). Le système de santé lao et ses possibilités de dé veloppement : la cas de la zone de santé de Thaïlande Düa. Texte remanié de thèse de doctorat en ethnologie. Comité de coopération avec le Laos, Paris, 505p.
[16] Pottier Richard (2004). Ibid, …..p.221. '43,7% de ceux qui ont eu recours à un traitement quelconque, ont en effet acheté des médicaments soit dans les pharmacies de Vientiane, soit (deux fois plus nombreux) dans celles de Thaïlande. Il est à noter qu'un quart du nombre total de malades (119/476) et 30,6% de ceux qui ont eu recours à un traitement, ont acheté des médicaments en Thaïlande. L'achat de médicaments dans une pharmacie thaïlandaise a, en fait, représenté le type de traitement le plus souvent utilisé.'

Transborder movements of health are thus seen to have existed for a long time and are part of the practices of the Lao people living near the border. The issues to investigate today are to know first of all if these movements of proximity were influenced by the development of transport infrastructures on both sides of the border and thus if they have increased. It is also a question of whether these movements of proximity were accompanied by mobility where the distance covered on both sides of the border was increased? Is there surimposition of these two types of movement?

RESEARCH HYPOTHESES

1. **The medical differential observed in the level of health care infrastructure between Thailand and Laos is the primary factor affecting the mobility of Lao patients.**

The border area composed by Laos and Thailand is an original space; there is a strong economic and medical gap on both sides of the border and it is this differential which encourages some Lao people to use Thai health care infrastructures, either because they are considered to be of a higher standart, or because they can give very specialized care. We can label this mobility as ‘health seeking movements’. To quantify these movements poses the issue of the attraction power in Laos of Thai health care facilities. What are the dimensions and characteristics of the catchment area within Lao territory for these Thai structures?
More specifically, we can ask for which types of care Thai facilities are generally solicited. And, finally, who benefits from the Thai medical provision?

From this general hypothesis, we can more specifically focus on the border situation between Vientiane and Nongkai: the bridge between these two cities has doubtless stimulated movements on both sides. What are the consequences in terms of the attractiveness of Thai hospitals and private clinics ? Just how far does "the bridge effect» carry on the Laotian side?

2. **The choice of whether or not to utilize the Thai health care infrastructure is a complex combination of the degree of accessibility, the gravity and the urgency of pathology as well as the profile of the patient (socio-economic, cultural and ethnic**

status). It will therefore be necessary to compose various trajectories according to these different parameters.

a) At the time when patients choose health care facilities, the first element taken into account is the distance which separates the patient from the facility. But this distance can be understood in three different ways: physical and real distance, time-distance and the more subjective distance which is perceived and lived by men.
The first meaning is thus about the issue of real accessibility. What distance (in kilometres) will patients travel to be treated? Does there exist a limit beyond which patients do not cross the border for healthcare?

Time-distance focuses more on the duration of travel between two places than on simple physical distance. In the case of our study, the good state of roads, the simpler and faster customs controls as well as the recent daily shuttle bus in both directions (in the case of the border area between Vientiane and Nongkai), tend to reduce the journey time and consequently to bring closer the places on both sides of the border.

Finally the relationship between men and places still goes beyond the physical, geometrical distance. Armant Frémont spoke about "the emotional distance, with a strong psychological component, [which] can come between a man and a place, or between men and places, more than the measured length and time of route, an emotive power depending on various factors (from simple habit to myth) which has the effect to connect or on the contrary to estrange[17]". This is what we call the perceived distance by men. For example, the presence of family members on the Thai side or the habit of going there often for reasons such as shopping, leisure etc, will tend to minimize the effect of distance.

All these questions about real and perceived distance will be thus the first element to take into account in looking at health seeking behaviour.

[17] Frémont A. (1982). Histoire d'une recherche : distances et espaces, in *Espaces vécus et civilisations*, Paris, CRNS, p.26. 'La distance affective,à forte composante psychologique, fait intervenir entre un homme et un lieu, ou entre des hommes et des lieux, outre la longueur mesurée et le temps de parcours, une charge d'affectivité tenant à divers facteurs (de la simple habitude jusqu'au mythe, à la religion) qui a pour effet de « rapprocher » ou, au contraire, d'«éloigner ».'

b) The choice of structure will also be established according to the gravity of patients' pathologies and their sudden and urgent nature. Are there differences in the choice of health care facilities and places of treatment according to the pathologies affecting the patients?
We would tend to think that patients who have grave pathologies (such as chronic diseases, standard diabetes and serious diseases such as cancer) choose to be treated in larger specialized health care facilities. However these structures are often not in border cities but further inside Thai territory (for example Udon Thani or Khon Kaen). And so, on the contrary, in the case of acute emergency pathologies (such as road accidents.), the choice will be for structures immediately at the border, where accessibility is easiest.

c) Lastly, I will endeavour to study health care behaviour according to the patient himself, his socio-economic and cultural level and his ethnic membership as well as his day to day environment.

Health care behaviours reflect varied patients' profiles. Indeed, crossing the border implies both knowledge of the care facilities fixed on the other side of the border and also having enough money to cover the expenses related to displacement and care. We could thus a priori say that patients who are treated in Thailand come from the Lao upper-middle-classes. Through a qualitative study, I will try to answer this assumption.
Moreover, in the case of Vientiane, we know that the city is made up of several national groups (lao, Chinese, Vietnamese) gathered in districts and also of diffenrent ethnic groups. Does the recourse to health care in Thailand depend on the patient's cultural membership?

3. **The Lao recourse to care in Thailand is initially an urban behaviour which tends to then be diffused to recently urbanized zones, with still some rural components in the case of Vientiane.**

Parallel to the research on patient profiles, it will also be interesting look at the issue of the nature of the place of residence of patients who choose to cross the border. Are they rather townsmen or rural? In the case of the border area between Vientiane and Nongkai, do they come most frequently from the city centre and close peripheries or also from surrounding villages? We could expect to see the phenomenon of mobility is a rather urban phenomenon.
These kinds of data will help to identify places or districts which are most exposed to the departure of their population for health care structures in Thailand?

TYPES OF APPROACHES SUITED TO BORDER SPACES.

The border is complex and difficult to define. This is why I present here various types of approaches which I will keep in mind throughout the field work in order to understand as well as possible border reality.

Need for a regional approach

To be comprehensive, a border study must be a balance of two complementary orientations: a systematic approach which includes a territorial, political, historical and identity exploration of the two border subspaces, and the approach known as regional which is more systemic and spatial.

The systematic approach is a technical one; it is in effect a question of describing and explaining in the most objective way possible the borderline and spaces on both sides of this limit. Within the framework of my present study, this systematic approach will consist of assessing medical provision on both sides of the border, as well the level of health care facilities, qualifications of medical personnel and specialities available; . The attraction of this reasoning is in the fact that spaces are apprehended in detail, but a major problem of this approach is that the spaces are described out of context, without reference to the regional situation. The information regarding either side of the border forms two independent studies which ignore each other and the risk of such reasoning is to then want to compare these two spaces without finding a closed link.

The integrated and regional approach is consequently essential in the case of border research as the objective is to link two independent subspaces and derive common characteristics from them. This reasoning can be described as all-embracing or global. Its intention is to enumerate the roles and multiple effects of the border on social groups and their spatial organizations on both sides of this limit.

The border: a multiscale concept

The characteristic of the border is also its capacity for being seen from several points of view, which I will all endeavour to take into account during the study.

'Borders form [...] multiscale objects, spaces subjected to strategies and policies decided on different levels of capacity [...]. The articulation of scales, sometimes the confrontation between a tendency to centripetal integration and a centrifugal drift animated by logics of proximity, demonstrates the need to study borders on different scales[18].'

Within the framework of health movements, I will thus endeavour to develop various points of view to carry this work on the border through to a successful conclusion; first of all it will be necessary to put ourselves in the place of Lao patients who cross the border and to understand their step. What are the factors which justify this choice? For which type of pathologies do they seek treatment in Thailand?

Then we will take the point of view of persons in charge of health facilities in Laos and Thailand in order to identify their perceptions of the border. Finally we will approach the border and movements of Lao patients from the point of view of local people in charge of communities (heads of villages/districts in cities) as well as the persons in charge of health issues in each of the two countries.

The various actors mentioned here are hypothetical, however one thing is sure: during my study, I will endeavour to associate divergent perceptions around the border in order to draw out a global representation.

Multi discipline approach

'Objects of reality and spatial organization, borders are also objects built by our cultural and ideological values (...). They refer to three different and complementary fields:

[18] Collectif Renard J-P., Veyret Y… (2002). *Limites et discontinuités en géographie*, Liège, SEDES, Collection Dossiers des Images Economiques du Monde, 160p. 'Les frontières forment […] des objets multiscalaires, des espaces soumis à des stratégies et des politiques décidées à des échelles de pouvoir différentes […]. L'articulation des échelles, parfois l'affrontement entre une tendance à l'intégration centripète et une dérive centrifuge animée par des logiques de proximité, démontre l'intérêt d'étudier les frontières à des échelles diffé rentes.'

reality, imagination and symbolic systems[19].'

We have noted that the border constitutes a network of limits created by men which is translated in the landscape and concerns geography. But there are also all the consequences of this network in practices and attitudes as well as social structures and that do not concern geography directly. The richness of the border topic has made it a research field common to almost all social sciences.

In the course of my research, I will therefore try hard to enrich my geographer's point of view with research undertaken by public health experts, historians, sociologists, psychologists and ethnographers and I will endeavour as much as possible to collaborate with them.

STUDIES AREA

The border between Laos and Thailand is 1754Km long, of which more than two thirds is delineated by the Mekong. It is the link between a great number of Lao and Thai provinces and is thus extremely heterogeneous, bringing into contact spaces of very different natures depending on where we look. To define well the research locales is essential because the choices made will affect the way in which my objectives are answered. The selection will thus be made keeping in mind the need for a large amount of heterogeneity in order to enable comparison of various border situations and create a broad vision of the phenomenon of Lao health care seeking behaviour in Thailand.

Detailed below are the selected study zones which appear interesting (see map 1):

- The first border area consists of Vientiane - Nongkai/Udon Thani/Khon Kaen and, to a lesser extent, Bangkok. In Laos, the capital is the city best provided for in terms of health facilities and personnel, however there are flows of health seeking behaviour of a more or less high intensity towards all of the 4 cities referred to above. Up to what point are these movements quantitatively important?
- The second border region is the one between Savanakhet and Mukdahan / Khon Kaen. This area was described as the "East-West corridor" of the Greater Mekong Sub-region by the

[19] Foucher Michel (1988). *Fronts et frontières. Un tour du monde géopolitique*, Paris, Fayard, 691p. 'Objets de la réalité et de l'organisation des espaces, les frontières sont aussi des objets construits par nos valeurs culturelles et idéologiques. (…). Elles nous renvoient à trois champs différents et complémentaires : le réel, l'imaginaire et le symbolique.'

ADB and has seen great changes with the construction of a bridge which will connect the two border cities in few years. In this zone, the issue will be to take note of developments now in progress and measure their repercussions in terms of health and movements on both sides of the Mekong

- The border area between Pakse and Ubon Ratchatani will be also a zone of study. One of the special characteristics of this area lies in the fact that Pakse is not strictly speaking a border city. Here we will look carefully at the effect of distance on the movements of people living in Pakse.
- The final study area is located further north, between Bokeo and Chang Rai provinces. Bokeo is really on the periphery of the central zone of Laos and we can ask whether this has an impact on its relations with Thailand and more precisely on its health movements.

Each one of these zones thus presents specific characteristics to be developed and taken into account in the data analysis in order to clearly identify the specificities of medical mobilities peculiar to each place.

Locations of 'health seeking behaviour of Lao patients in Thailand' study areas

Map realized by A. Bochaton adapted from Atlas of Lao PRD 2000, Sisouphantang B. and Taillard Ch.

METHODS AND DATA

Analyze quantitative information

The first step that I will carry out in studying the target areas, will be to define and characterize the health care infrastructures on both sides of the border. This will enable me to fix the context in which the flows of health seeking behaviour in Thailand take place. On the

Lao side and more precisely in Vientiane, I will be brought to work with Virginie Mobillion, PhD student in geography of the health who studies health care facilities in detailed way.

Once this first issue has been explored, the largest amount of quantitative work will take place in Thailand and will be to consult the patient registers in hospitals and private clinics along the border but also further inside the territory, in cities like Udon and Khon Khaen to evaluate, taking into account the reliability of the data, the number of Lao patients who come to each of these structures for treatment. This will lead me to evaluate what the areas of attraction are for Laos of each Thai public and private structure.

The localization of each establishment will be done by GPS in order to establish maps of this attraction, according to the nature of the infrastructures (public, private), their localisation in Thailand (close to the border or not), their specialities….

If available I will also try to collect older data in order to estimate the evolution of flows of health seeking behaviour in the last few years: is there a growth in this phenomenon related to the development of transport infrastructures on both sides of the border?
Also, the presence of customs on the bridge between Nongkai and Vientiane and the Department of Highways in Nongkai will certainly allow me to quantify flows in general and more specifically of patients who cross the border by the road.

Qualitative approach

On top of the quantitative research which will form the basis of reflections regarding context, I will also adopt a qualitative approach in order to focus on the behaviour of the transborder patients, their profiles and their strategies. The qualitative approach, through a household survey, will allow me to better understand flows of recourse, the factors which determine them and the modes in which they operate. Some axes present particular interest:

- Patient profiles: first, I would like to define categories of patients who leave Laos and go to Thailand to receive treatment. That implies taking note of their socio-economic status, their ethnic and cultural specificity and locating their place of residence in Laos. All elements from an individual or familial point of view will be taken into account in the elaboration of these different categories.

- Operating modes of flow: The way in which flows occur also particularly interests me. With this information, I will be able to reconstitute the patient's therapeutic routes. This can be summarised by a series of questions: How did the patients know about the structures of care present in Thailand? When a patient chooses to cross the border, is it an individual action or is the patient supported by family or networks of another type? We know indeed that a great number of Lao people live in Thailand, consequently we can ask whether family ties on both sides of the border always exist and if they play a part in access to health care structures in Thailand. Can Lao people who live in Thailand facilitate access to health care infrastructures for members of their family living in Laos?

  Do family strategies on care exist? It will be necessary here to try and reconstitute family ties and genealogies on both sides of the border.

- Health seeking behaviour / Classic movements on both sides: Finally, I would like to consider the traditional economic activities (exchanges, shopping, leisure activities...) carried out by Lao people in Thailand and those who go specifically to Thailand to seek health care. Are they the same individuals? Does the consultation to a doctor or in a hospital coincide with other economic activities or is it the single motivation which pushes some Lao people to cross the border?

To study movements across a border is a difficult thing because of the imperceptible and dispersed nature of this phenomenon. The qualitative approach will thus undoubtedly allow me to approach flows of recourse in a more detailed way and consequently understand better the current process of health care movements.

DIFFICULTIES REGARDING THE INITIAL FIELDWORK

One of the difficulties which will come up during the study is the variability of access to registration data depending on the status of the health care infrastructure (public hospitals or private clinics) and consequently a statistical imbalance at the time of analysis. Registers in public hospitals are on the whole easy to obtain whereas those of the private sector are much less so. As a result I won't be able to make a quantified comparison of the attraction of private structures in relation to the attraction of the public sector.

CONCLUSION

Health mobility is a phenomenon that has always existed, both in proximity to and on both sides of the border between Laos and Thailand, as a study made in the early seventies by Richard Pottier, has already proved. Today's changes concern the amplification of movement in terms of intensity, space range and organization/structuring following the opening and development of the border.

Ultimately, the study on health seeking behaviour from Laos to Thailand has several objectives, including:

- To identify old flows and those which are the result of new practices, related to a general increase in movements on both sides of the border.
- To identify the most relevant scale for understanding well these health mobilities: from the transborder scale, made of spontaneous movements of proximity, to the transnational, which finds expression in reticular operations. Which logic prevails today?

Can we imagine that there is today a combination of these logics leading to a complex organization of border areas? What are the new spatial articulations which result from this?

It is the mission of this research, undertaken in the geography of health, to answer these questions.

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Ethnic groups and HIV/AIDS in Ky Son district, Nghe An province, Vietnam, 2004

Tran Thi Nga, Phan Vu Diem Hang, Ngo Duc Anh

I. Background

Since the first case of HIV infection was reported in Ho Chi Minh City in 1990, HIV has now been identified in all 64 provinces and cities of Vietnam. Nghe An - a central province of Vietnam - is not an exception. According to the Nghe An Provincial AIDS Standing Bureau, by February 2004, a total of 2,814 people have been found positive with HIV in the province.

This study has been conducted in the project *"Strengthening bilateral cooperation between Nghe An province (Vietnam) and Xieng Khoang province (Laos) in HIV/AIDS prevention*" to provide baseline information of ethnic minority populations and HIV/AIDS in 4 selected communes (Muong Xen, Chieu Luu, Huu Kiem, and Nam Can) of Ky Son frontier district, Nghe An province.

Ky Son, a remote mountainous district of Nghe An, shares 192 km of borderline with Laos in the north, west and south, and connects to Noong Het district, Xieng Khoang (Laos) through Nam Can international border gate. It has a population of 58,000 people, of which 90% are Thai, H'Mong, Kho Mu and K'Ho. Stretching over 1,791.7 km2, Ky Son is divided into one town and 20 communes. Located in the Truong Son Range, Ky Son is 800 - 1000 m above the sea level, subsequently it has rather harsh and changeable climate, and is difficult to access. The national road No. 7, connecting Vinh city and Nam Can border gate, spans over 300 km and is full of twists and turns. In communes where this road passes by, local people tend to cluster around the road.

Local ethnic groups enjoy a mix culture of their own traditional one and of the modern one. They wear both traditional and modern costumes in everyday life and during festivals. They eat both traditional food and food prepared following the Kinh people. Traditional activities – carnivals, festivals, or community gatherings – have gradually given place to public activities, or ceremonies celebrating national events such as the National Day (September the 2nd), the Communist Party Day (February the 3rd), and the birthday of Vietnamese beloved former president Ho Chi Minh (May the 19th). During these events, some traditional activities such as playing traditional music, dancing or singing performances, or buffalo's fighting competitions, are organized together with other modern cultural activities. These often attract people from different ethnic groups, social classes, and ages.

Majority of the population in the district lives on farming, castle raising and timbering. Farming season lasts from April to June; harvesting season is from October to December. In the planting and harvesting season, farmers usually stay in the field from four or five days due to the distance from home to the field. January – March period is the leisure after harvest time. In remote villages, self-supported economy holds a prominent position. A small portion of the population who resides along the national road number 7 and in Muong Xen town earns their living by doing small businesses or producing traditional handicraft products.

There is a coexistence between languages of ethnic groups and the national language (the language of Kinh). The majority of ethnic populations can speak Kinh – village leaders speak it fluently. Some people can also speak languages of other ethnic groups. However, many H'Mong and older people living far from the national road cannot speak and understand Kinh.

All local residents do not adhere to any religion. They only pray their ancestors. In each family, the husband is the breadwinner, and the wife assists him in farming, educating children, and doing housework. In each village, the village leader is the most respected person whose ideas have strong influence on others.

Although four communes included in the project share common characteristics of a mountainous area, each has its own features – they are different in the ethnic composition and geographical location (Table 1).

Table 1. Demographic characteristics of the communes within project sites

Commune	*No. of Villages*	*Households/ Residents*	*Ethnics*	*Geographic surface (ha)*
Muong Xen town	5	478/2264	Kinh (48.7%), Thai (30.8%), H'Mong (10.5%), Kho Mu (8.6%), Hoa (1.1%), K'Ho (0.3%)	169
Chieu Luu	11	912/5230	Thai (60%), Kho Mu (35%), Kinh (4.5%), H'Mong (0.5%)	12,171
Huu Kiem	8	626/3651	Kho Mu (70%), Thai (27%), Kinh (3%)	789
Nam Can	6	513/3284	H'Mong (65%), Thai (19.5%), Kho Mu (15%), Kinh and Hoa (0.5%).	9,076
Total	**30**	**2,529 / 14,429**		**22,205**

Figure 1. Map of Ky Son District

II. Research Methodology

The study included two components, qualitative and quantitative ones. Qualitative research used focus group discussions, in-depth and key informant interviews to gather relevant information. The quantitative research employed a random household survey to provide an estimation of extension of certain variables.

II. 1. Quantitative research

The questionnaire was developed to provide the following major indicators:

- Percentage of people who can promptly name at least 3 modes of HIV transmission;
- Percentage of people who can promptly name at least 3 measures of HIV prevention;
- Percentage of people who give correct answers on how HIV is transmitted and not transmitted;
- Percentage of people who give correct answers on how to prevent HIV infection;
- Percentage of people who have known and reported to use condoms; and
- Percentage of people who show sympathetic attitudes towards HIV infected people.

The survey used the random sampling method. Survey area included 12 selected villages in 4 target communes – either along the road number 7 (roadside village) or having high numbers of drug users. Households were selected randomly, and interviewers visited these during the daytime from 9 a.m. to 5 p.m. Some people met on the street were also included in the survey. A total of 272 interviews had been conducted – twenty failed to meet the quality standards, and were excluded from analysis.

Table 2. Number of completed interviews by commune

Commune	*Number of completed interviews*	*Percentage*
Muong Xen	71	28.2
Chieu Luu	62	24.6
Huu Kiem	59	23.4
Nam Can	60	23.8
Total	**252**	**100**

II. 2. Qualitative research

Tape-recorded In-depth Interview (II), Key Informant Interview (KII), and Focus Group Discussion (FGD) were key tools for collecting qualitative information. In addition to these, observations were made during visits to the project sites.

The study subjects were recruited, using purposive and random sampling. Informants included local government officials, members of social organizations (Women Union, Youth Union), community members (men, women, youth, traditional healers, and traditional birth attendants), community health workers, school teachers, cross-border traders, border keepers and drug users. In total, 32 in-depth interviews and 8 focus discussion groups have been conducted.

Table 3. The composition of study subjects in the qualitative research

Study subjects	*In-depth Interview*	*Focus Group Discussion*
District government officials	-	1
Commune government officials	-	4
Village leaders	4	
Teachers of the boarding school	-	1
Students of the boarding school	-	1
Village health workers	4	-
Traditional healers	1	-
Traditional Birth Attendants	1	-
Male adults	7	-
Female adults	7	-
Cross-border traders	2	-
Border keepers	-	1
Drug users	6	0
Total	**32**	**8**

III. Findings

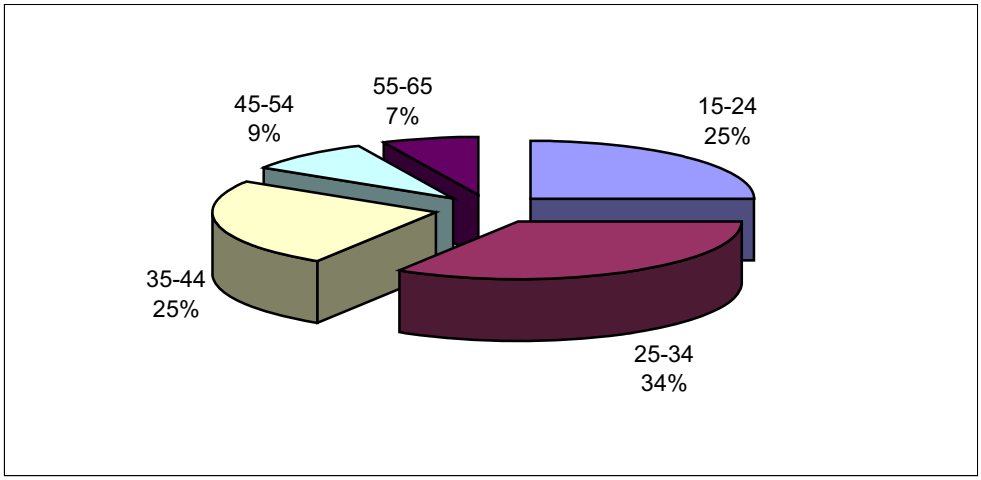
III. 1. Characteristics of the population

1. Demographic characteristics of the respondents

Age: People included in the survey were from 15 to 65 years old for both genders.

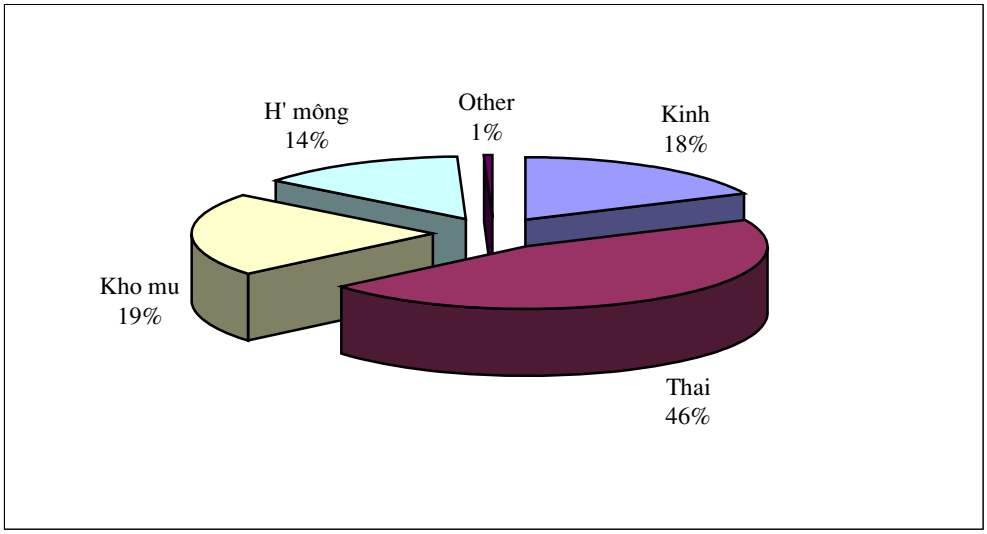
Gender: 48% of respondents were female, and 52% were male.

Figure 2. Distribution of respondents by age group



Ethnics: Thai group accounted for the largest proportion in the survey (46%), followed by Kho Mu (21.5%), Kinh (18%), H'Mong (14%), and others (K'Ho, Hoa) (0.5%).

Figure 3. Distribution of respondents by ethnics



Residential status: 87.3% of respondents came from Ky Son, and 12.7% were migrants coming from other districts or provinces.

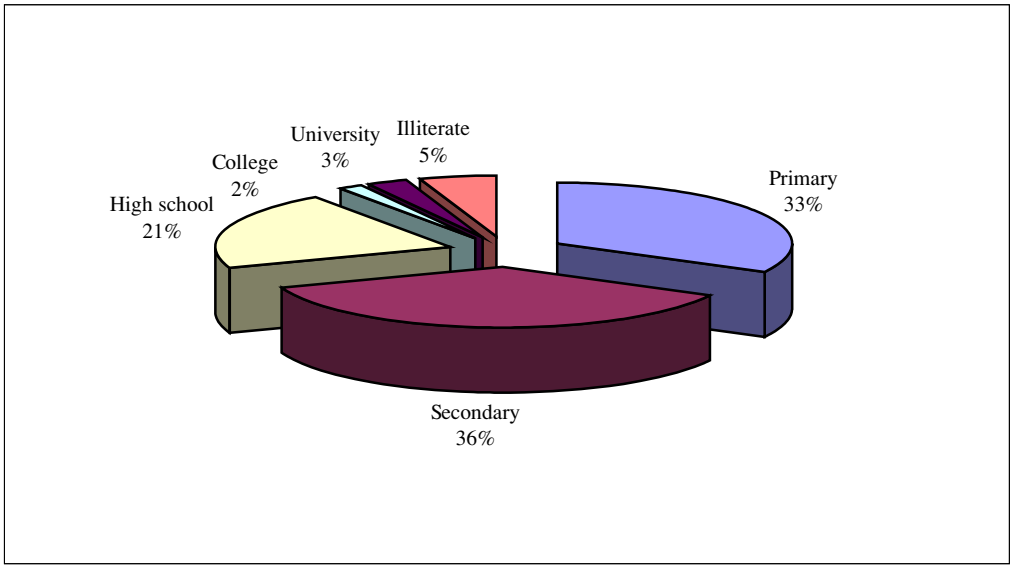
Religion: Almost all (98%) people in the survey did not belong to any religion.

Occupation: 67% lived on farming or timbering, 9% worked for the government, 7% were students, 4% were small traders, and 13% did other jobs such as production of handicraft goods, or unemployed.

Levels of education: only 5% respondents reported to be illiterate, 33% completed primary school, 36% completed secondary school, and 21% completed high school. Only 5% graduated post-secondary education (college or university).

Language: 95% of respondents could speak and understand Kinh.

Figure 4. Distribution of respondents by level of education



III. 2. HIV/AIDS situation and potentials for its transmission

1. General situation of HIV/AIDS

HIV figures:

By February 2004, in the whole province of Nghe An, out of a population of more than 3,000,000, a total of 2,814 people had been found positive with HIV (94 per 100,000 inhabitants). Also by February 2004, in Ky Son, with the population of 58,000, there had been 10 positive cases (17 per 100,000) – all had been detected during the army conscript screening due to the fact that there were no testing services available there.

Yet 8 out of these 10 cases were young people from the 4 project communes, making their detected infection rate 3 times higher that the district's average (8 per 14,429 inhabitants, or 55 per 100,000). And moreover, 6 were from Chieu Luu commune (5230 people) – roughly

estimated detected prevalence was 115 per 100,000 inhabitants and 2,620 per 100,000 drug users.

All these 8 HIV cases belonged to the group of 550 drug users in the 4 communes. However, the real number of HIV infections must be higher if not only army conscripts were tested.

Table 4. Drug users and HIV cases detected by February 2004

Commune	*Drug users*		*HIV cases*		
	No.	*% in population*	*No.*	*Rate per 100,000*	
				Of population	*Of drug users*
Muong Xen	135	6.0	1	44	741
Chieu Luu	229	4.4	6	115	2,620
Huu Kiem	97	2.7	1	27	1,031
Nam Can	89	2.7	0	0	0
Total	**550**	**3.8**	**8**	**55**	**1,455**

Knowledge

Although 92 % respondents said they heard or knew about HIV/AIDS; and 90% knew that HIV/AIDS was a fatal and incurable disease, in general the population's knowledge of HIV/AIDS was still very poor. Regarding individual route of HIV transmission, 82% respondents cited injecting drug use, 62% cited having sex without condoms. This rate for mother-to-child transmission was 20%.

The qualitative assessment also revealed that existing knowledge was vague and inadequate. There was a confusion of how HIV was transmitted or not transmitted, and how to prevent HIV infection. However, commune officials who participated in group discussions and in-depth interviews all had good knowledge on HIV transmission routes and HIV prevention measures.

> *"If you get that disease, you cannot live for long" (II – 26 year old man)*
>
> *"I do not understand much. I heard that if IDUs share one needle and syringe, they will get HIV. Thus, I tell my son not to use drugs anymore." (II – 41 year old woman).*

Knowledge of how HIV was transmitted confined greatly to drug injection and sexual contacts. People tended to think that HIV was only transmitted among drug users, while they were not aware that sharing or using non-sterilized syringes/needles could also transmit HIV. Blood transfusion and mother-to-child transmission was mentioned by just a few informants.

Respondents who knew that HIV could be transmitted by sharing clinical needles accounted only for 23% interviewees. There was a substantial number of respondents, around 20%, thinking that HIV/AIDS was not transmitted through sexual contacts without condom, via blood transfusion, or from an infected mother to her child.

Being asked of some ways in which HIV was not transmitted, many respondents gave incorrect answers: 40.5% blamed mosquito bite, 19% - sharing kitchen utensils; 18% - holding / kissing, 18.5% - coughing, and 18.7% for sharing toilet.

Regarding assessment of HIV infection risk, only 26% respondents thought they could get infected, 42% believed that the highest risk group was IDUs, and 36% cited sex workers.

Proportion of respondents who promptly named at least three measures of HIV prevention was 25%. Figures of those who gave correct answer on one preventive measure was 47% for not sharing syringes/needles, 41% for using condoms consistently when having sex, and 29% for being faithful to one partner.

A substantial number of respondents agreed that avoiding mosquito bite (37%), not sharing meal with an HIV carrier (33%), or not sharing toilet with an HIV carrier (25%) were methods to prevent HIV infection.

"HIV is transmitted via the respiratory tract" (II – 19 year old male).

"In my opinion, only youth at the age of 25 – 30 could get HIV infection while those over 30 years of age could not" (II – village leader).

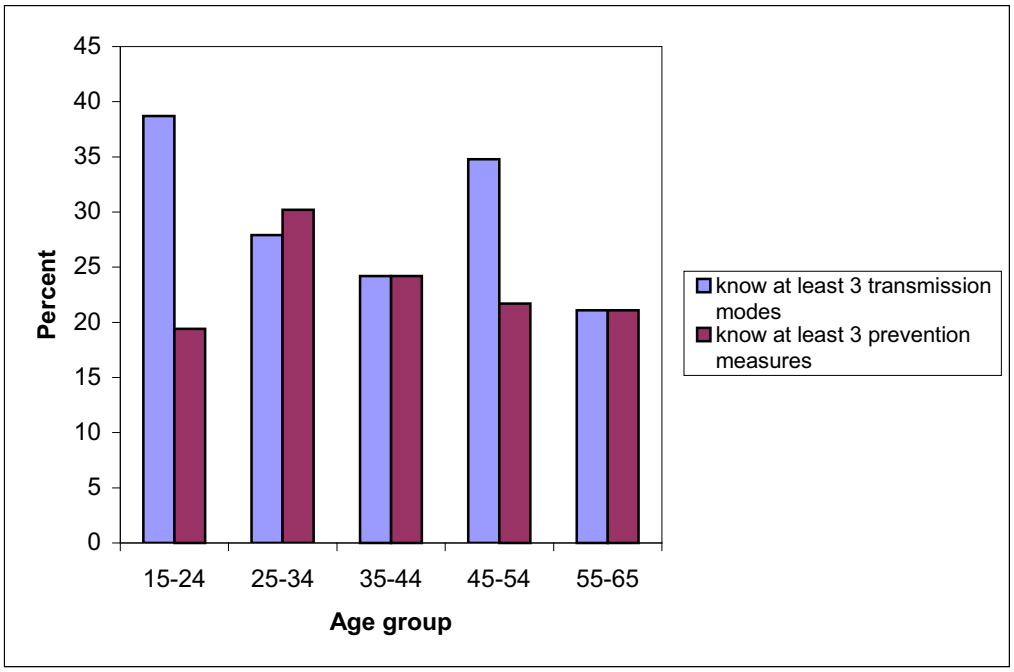
"Because they smoke opium – I do not know much. I only know IDU can easily get infected with HIV" (II – 17 year old girl).

"We do not have any relations to that disease (HIV). We heard about it from an outreach worker, but I do not understand much" (II – 50 year old man)

"There is a vaccine to prevent HIV" (II – 28 year old woman).

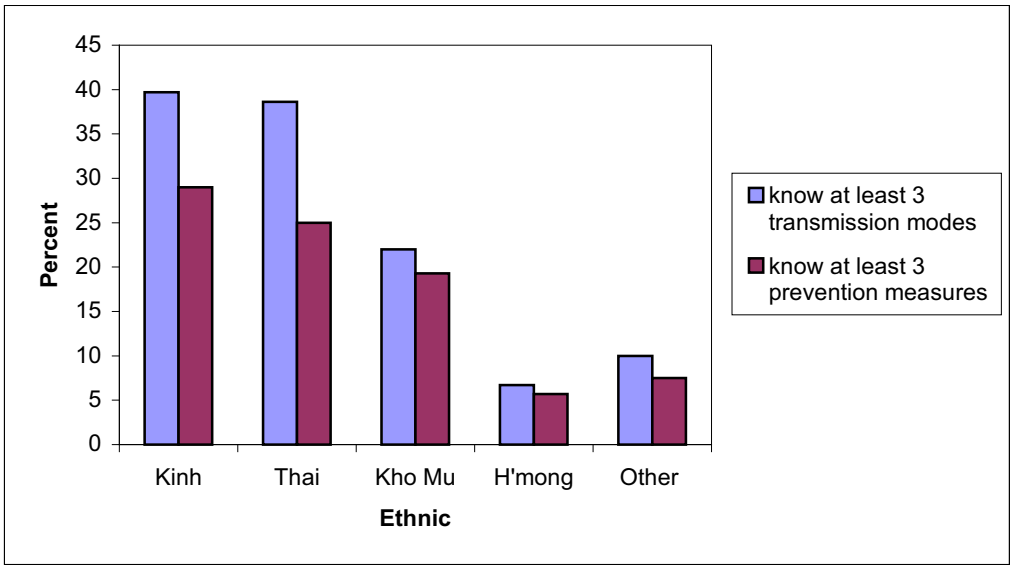
Knowledge of HIV/AIDS was also different across age groups. Youths aged 15 – 24 and people aged 45 - 54 were the most knowledgeable on how HIV/AIDS was transmitted: 38% and 35% of them knew at least three HIV transmission routes. Corresponding figures of other age groups were 28% for people 25 – 34 years old, 24% for 35 – 44, and 21% for 55 – 65 ones. Surprisingly, proportion of youths who could name at least three preventive measures was the lowest compared to other age groups. However, this indicator for all five age groups was not significantly different, ranging from 20% to 30%.

Figure 5. Knowledge of HIV/AIDS by age group



Knowledge of modes of HIV transmission and preventive measures were different between ethnic groups. In general, Kinh and Thai people had better knowledge than Kho Mu and H'Mong ones. H'Mong people were far behind other groups in terms of knowledge of how HIV was transmitted – only 6.7% of them could promptly name three modes of HIV transmission.

Figure 6. Knowledge of HIV/AIDS by ethnic group



2. HIV/AIDS and blood born transmission / drug use

Ky Son district had once been famous for opium plantation. Therefore, drug addiction, using non-injecting practices such as smoking or swallowing (for disease treatment purposes) was quite common in both men and women. Opium was a home made product, thus, opium use did not have great impact on household's economy and social security, and no one discriminated opium users.

> *"If I stop using drugs, I feel very painful" (II – 45 year old female).*

"Drug using family" – a family in which all members were drug addicts – was a common phenomena: once the father got addicted, his children could easily imitate this practice.

> *Q: Why did you get addicted to drugs?*
>
> *A: My father was a drug addict - when he was busy, he asked me to buy drugs for him. Sometimes, I felt stomachache and I asked him to give me opium to swallow.*
>
> *Q: Did you feel better after you used it?*
>
> *A: Yes, then I got addicted (II – 28 year old male drug user)*

In a drug using family, it was very difficult for one family member to give up using drugs.

> *"I have tried to stop using drugs 3 times, but I failed. My father is still using. When I see him smoking, I can not bear" (II – 28 year old male drug user).*

Since the government policy on elimination of opium plants was launched with the support of the United Nation Office for Drug Control (UNODC) in 1996, leading to the complete chop-down of opium plants, opium supply became scarce and drug users had to go to Laos seeking opium for their use. Simultaneously, they also engaged in transportation and trafficking drugs through small trails. Making use of this situation, some Kinh people from other districts and provinces brought in heroin and other synthesized drugs for selling to local drug users who were mainly young people.

Increasing price of drugs and increased dosing induced drug users in Ky Son to shift from non-injecting to injecting practice, particularly in Chieu Luu commune, dozens of opium smokers became injecting drug users. Most drug users spent more money than their income for drugs. For this reason, drug use had greatly impacted household's economy and social security, and resulted in the discriminative attitude of general community towards drug users. The very discriminative attitude prevented injecting drug users (IDUs) from accessing clean syringes/needles and other health services.

Young drug users often used heroin and synthesized drugs. Middle or older age people preferred smoking opium, making up 60 % opium smokers, as estimated by the district officials. Some people swallowed drugs (a common traditional practice). About 27% drug users were IDUs, mainly young people. Most drug users were men of different occupational backgrounds.

> *"Drug users could be school teachers, students or government officials, but they often hide their drug use status" (II – 37 year old male IDU).*

Major risk of HIV transmission was the changing pattern of drug use from smoking to injecting due to the escalating drug price, and the fact that injecting drugs could produce faster effects.

> *"For the drug users who have been using drugs for long time, they require higher doses of drugs, so they prefer injecting which is much cheaper" (II – 47 year old man).*

When drug users were craving for drugs, they often practiced unsafe injection such as sharing and using un-sterilized syringes/needles, or injecting drug residue.

> *"When he is hungry for drug, I see him pour liquid with opium residue into a syringe, then inject it" (II – 28 year old male, former drug user).*
>
> *"When he is craving for drug, he defies everything to satisfy his addition. He borrows syringes/needles from others" (II – 50 year old male drug user).*

Besides, most IDUs thought that they should not have to take HIV tests if they still felt strong.

3. HIV/AIDS and sexuality

Commercial sex was also reported in Ky Son. Increasing interaction between local residents and other localities through migrant workers, truck drivers, cross-border traders stimulated sex work and drug use. Sex workers included those from other localities or even from Laos. There was one brothel located in Laos near the border gate to serve transiting drivers.

> *"Sex work in Laos is not controlled as strictly as in Vietnam. Sex workers from Laos do not enter Vietnam through the national border gate, but through small trails. Some youths, primarily belonging to ethnic groups who have rather good living condition, experiment sex with sex workers" (FGD - district policeman).*

Benefited from population and family planning programs, and SHAPC's previous project on HIV prevention, local people had heard or known about condoms and the importance of condom use for both contraception and prevention of STD/HIV/AIDS. However, they still felt ashamed or reserved to talk about this topic. Therefore, it was very difficult for interviewers to delve deeper into this topic to have an adequate assessment of their knowledge and behaviors related to condom use, as well as condom use skills.

Some people had never used condoms though they had heard about it. They showed an indifferent attitude towards condom use by explaining that they did not like it or did not think it was necessary to use it. Many informants said they did not know how to use condom properly, since they had never been guided to use either by health workers or outreach workers.

> *Q: What is condom used for?*
>
> *A: For preventing diseases such as: HIV, syphilis, and pregnancy.*
>
> *Q: How to use condom properly?*
>
> *A: I do not know much because health workers have just introduced it to me but have not guided me on how to use condom properly" (II – 24 year old woman).*

Proportion of respondents who knew or heard about condoms was 67%, but only 19% said they had used condoms. Among those who used condom, 76% said they used it for contraception, 52% for prevention of HIV/AIDS, and 22% for prevention of STDs. 83% condom users used it when having sex with spouse, 10% with boy/girl friends, and 8% with sex workers.

The place where people liked to get condoms from was the commune health center (51%). Only 26% wanted to buy condoms from private pharmacies, and 23% from other sources such as health workers, outreach workers, public pharmacies or hospitals.

4. HIV/AIDS and mother to child transmission

As mentioned earlier, only 20% interviewees knew that HIV could be transmitted from an infected mother to her baby. This reflected the big gap in the knowledge of local population regarding HIV/AIDS matters.

III. 3. Factors related to HIV transmission

1. Socio-economic factors

Drug addiction and emerged discrimination towards drug users:

Unemployment and lack of healthy entertainment facilities and recreational activities had been cited as important factors promoting drug addiction among youths and adolescents.

> *"There is a shortage of entertainment or recreational activities such as cinema, music performance, or sports. When having free time, youths gather and drink alcohol. Thus, they get addicted to drugs" (II – 56 year old male).*

After completing high school, many young people could not find jobs. They became depressed, therefore could be easily enticed by friends who were drug users or drug dealers. Drug dealers coming from plain regions with "white pills, red pills" which look curious to young people:

> *"These pills are very tasty, why don't you try?"*

To entice, they poured out alcohol until youths get drunken, then gave them free samples:

> *"Initially, I used it for relaxation, then I felt interested, and gradually I got addicted to drugs unknowingly" (II – 37 year old male IDU).*

Local people had different attitudes towards drug users. In villages where opium plants had been planted, villagers considered drug use a normal practice, and there was non-discriminative attitude against drug users.

Since the elimination of opium plants policy came into practice, drug supply and income of local residents dropped dramatically. Consequently, many traditional drug users could not afford smoking opium. Some of them had to sell household's belongings for money to buy drugs – this greatly affected family's economy and spouse's sentiment. Anti-drug campaigns of the government raised awareness of local residents of bad impacts of drug

use on their life. As a result, certain traditional drug users were willingly going to detoxification centers where they were given treatment to give up drug use. However, due to the lack of courage, a number of others (mainly young ones) maintained using it.

On the other side, the elimination of opium plants and anti-drug campaigns introduced stigma and discrimination of the general population towards drug users. Firstly, these lead to a sharp decline in local residents' income and an escalated drug price. To earn money for drugs, people often engaged in illegal activities such as stealing, robbery and drug trafficking. Secondly, drug use started to be considered as a social evil under the influence of campaigns' communication. As a consequence, stigma and discrimination of general population towards drug users had become stronger and stronger.

> *"Girls dare not come closer to him (IDU). If there is a festival, nobody dares to go with him" (FGD - Nam Can commune authorities).*
>
> *"Some people say they do not have any discrimination against me, but they see me with unfriendly eyes, they avoid meeting me" (II – 37 year old male IDU).*

Access to mass media including health education:

Another factor preventing people in the bordering areas between Ky Son and Noong Het district (Laos) from accessing mass media was the lack of electricity.

Among 4 selected communes, only Muong Xen town received electricity from the national network. In other 3 communes, electricity was generated by small-size hydroelectric generators – this power was used to run mass media facilities, but it was not adequate too. There was no electricity for daily life. Therefore, access to mass media (TV, radio) was very much limited.

Muong Xen town: In this the center of district, living standard of the population was relatively high. According to commune officials, about 65% households had televisions, 85% had radios or cassette players. There was a television station for receiving and broadcasting programs from national and provincial channels. It also broadcasted its own programs in the national language for local residents once or twice per week. Some households had satellite antenna to directly receive national television programs.

Additionally, local people in the town were accessible to national and provincial newspapers.

Chieu Luu and Huu Kiem communes: Inhabitants living in villages along the national road No. 7 enjoyed a more favorable condition in accessing mass media than those living in remote villages. As reported by commune officials, approximately 80% households had radios; some owned radios or cassette players. Each village had one television using battery which was administered by the village leader. Local residents preferred watching television to listening radios or cassette players. Most of them had some difficulty in understanding radio programs broadcast in Kinh. Twice per year, film and theatre performances were shown in the commune, but there was not much audience because of the poor geographical access.

> *"Number of audience is around 70 - 80 people, mostly youths. Elder people do not like it much" (FGD – commune authorities - Huu Kiem commune).*

Nam Can commune: This commune had no electricity, thus, it was difficult for its inhabitants to access mass media. A few households had radios. The whole commune had only one television set administered by the border keeping station. Villagers often came here to watch TV.

Mobile population:

Integration of cultures and lifestyles increased communication and interaction among people from different ethnic groups within the district, and with other communities in other locations, especially with cross border mobile populations and people from Vinh (the province's capital), who came here to work as traders or constructors. Living far away from home and lacking healthy entertainment facilities and recreational activities created condition for them to engage in drug use or unsafe sexual relations with local women. Thus, there existed a potential risk of spreading HIV from other localities to local residents in Ky Son, especially in road-side communes along the national road number 7.

Among four studied communes, Chieu Luu appeared to be at the highest risk of HIV transmission for several reasons. Chieu Luu had concentrated spots of injecting drug users for Ky Son as well as for neighboring districts. Chieu Luu was the gate to Ky Son – long

distance truck drivers from plain regions stopped over here before entering Ky Son. The commune's number of drug users and HIV carriers was the highest compared to other three communes (table 3).

Muong Xen town – the cultural-economic-political center of the district – was at the secondly high risk of HIV transmission with a substantial number of migrant workers and traders coming from other localities to work in construction sites or carry out small business at Muong Xen market.

Although no HIV infection had been detected in Nam Can – due to the lack of testing services – this commune could be considered as an area at risk because of its border gate, which attracted cross-border traders, and long-distance drivers from other districts or provinces. Furthermore, cross-border drug trafficking was simultaneously taking place at either the border gate or in small trails.

2. Cultural factors

Communication and literacy:

As four selected communes located along the national highway No. 7, it was easy for local inhabitants to access and have frequent exchanges with Kinh people. Therefore, understanding Kinh languague was no longer important barrier preventing them from accessing mass media and other channels providing specific information to ethnic populations. Up to 70% inhabitants could speak and understand Kinh– the common and official language in Vietnam. Languages of Thai, H'Mong, and Kho Mu were sometimes used in the market where people from different origins often gathered. Ethnic groups preferred using their own language in daily communication, which helped them easier and quicker understand each other.

Majority of interviewees in Muong Xen town completed secondary school. However, there was still a high illiteracy rate among older ethnic women.

In Chieu Luu commune, universalization of primary education had been completed in 1998, and universalization of secondary education should be completed in 2005 or 2006. Yet illiteracy rate was still high among people aged over 50 years old.

In Huu Kiem commune, different ethnic groups often lived together in the same village. Only a small proportion of Kho Mu still lived in isolation on mountains, hills, or along brooks – this habit prevented them from communicating and interacting with other groups. There were a few Kinh persons, they were mainly government cadres who came to help ethnic people improve lives and then settled down here – this group had the highest literacy, followed by Thai and Kho Mu. Majority of children from road-side villages were able to attend high school.

Literacy level of Nam Can's inhabitants was lower than that of residents in other communes. Secondary education was the highest attainted level. Illiteracy was common among the elderly and middle-aged people. A considerable number of ethnic people was not fluent in Kinh, especially among H'mong and Kho Mu women. This had limited people from communicating with Kinh people and understanding policies or guidelines of the central and local government.

Attitudes towards people living with HIV/AIDS (PHA):

Being asked whether PHA could live and work normally in the community, 54% respondents agreed and 46% disagreed. 26% showed their discriminatory attitudes towards PHA by stating that one should keep away from PHA. 56% thought that PHA needed to be cared and supported by the community, and only 4% said they could provide care and support to PHA.

3. Services

Access to health services:

Health infrastructure was relatively adequate in all the four communes. Every commune had a health center staffed by nurses and midwives. However, no commune health center had doctors. Each village had one village health worker.

Villagers often visited commune health centers when they got severe health problems – patients could receive treatment there or could be referred to the district health center depending on their status.

Commune health centers were equipped with essential equipment and medicines for primary heath care. However, this stock of medicines was still poor and many times patients must buy medicines that were rather expensive compared to their income.

Apart from this, residents living close to Nam Can border gate could benefit free medical consultation or treatment from military health staff in the border keeping station. Monthly, border keeping health staffs visited every village of Nam Can commune to provide free health check-up to villagers.

Yet difficult mountainous conditions had not allowed villagers to go to the commune health center easily. Walking from a village to a commune health center may take 4 – 5 hours.

Up to 60% pregnant women delivered their babies at home either by themselves or with support of traditional birth attendants. Some women even gave birth to their babies in the forest/farm.

> *Q: Where did you deliver your baby?*
>
> *A: On the farm, in a tent on the farm. The farm is one hour away from my home. There was no birth attendant. I delivered the baby by myself. My husband went to work. There was nobody besides me at that time. I cut the placenta cord by myself (II – 28 year old woman).*

Interestingly, unlike other places in Vietnam, there was almost no traditional healer in the area. Few families still invited sorcerers to expel bad things out of the body of sick persons.

Injecting practice:

Injecting medicine was a common practice administered by both village health workers and commune health center's staff. There was a widespread belief among local residents that injecting medicine could cure diseases quicker than taking medicine orally:

> *"Personally I think there is not much difference in treatment effects of oral and injecting medicines, but local residents prefer injecting medicine although injection can cause pain, because they think that it can cure a disease more quickly" (FGD - Huu Kiem commune officials).*

Both single-used plastic and multiple-used glass syringes were utilized. Yet, so far, commune and village health personnel had no chance to participate in any formal and intensive training on safe injection and safe disposal in the context of HIV pandemic.

Supply of syringes/needles:

Syringes/needles were often available at the pharmacies or local health centers. However, access to these in Ky Son was quite limited because there were very few pharmacies, and because of long and difficult ways from homes to health centers.

Therefore, when IDUs were craved for drug, they were very likely to share used syringes/needles with their mates, or reuse non-sterilized ones.

HIV/AIDS prevention efforts:

HIV/AIDS prevention in these four communes was inadequate and fragmented because it had been considered as tasks of some health care programs, such as programs on reproductive health, or primary health care. Mass organizations such as Youth Union and Women Union had some HIV prevention activities such as doing outreach work and group discussions on HIV with youth, but these had not been done on a regular basis. No intensive training on communication and propaganda skills for HIV prevention was organized for members of these organizations or for commune and village health staff.

HIV counseling and testing services were not available in Ky Son except for quick screening tests of HIV carried out in the detoxification centre. So far, only 10 HIV positive cases had been detected in Ky Son under the screening program with army conscripts and prisoners.

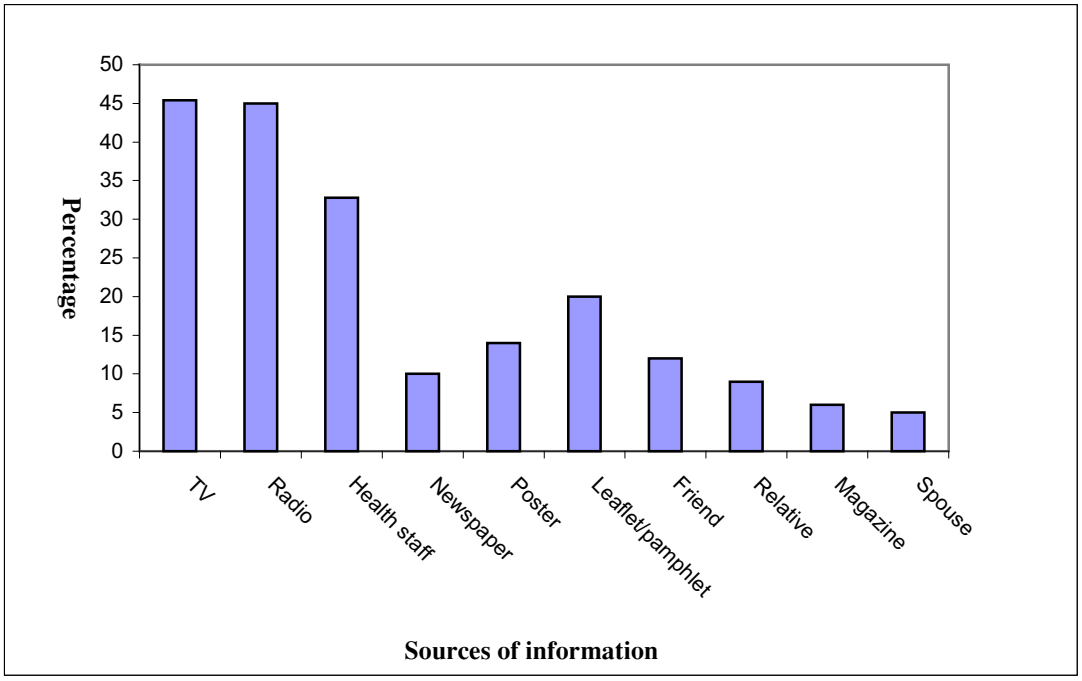
Fortunately, from April 2002 – October 2003, funded by Australian Agency for International Development (AusAID), SHAPC had implemented a number of HIV prevention activities targeted mobile populations at Nam Can border gate. From these efforts, some local residents had obtained certain understandings about HIV/AIDS.

Sources of information on HIV/AIDS:

IEC materials providing knowledge of HIV/AIDS to local inhabitants included panels and banners with slogans displayed in public places, or at the health centers. SHAPC had also distributed pamphlets but only in small number.

According to interviewees, TV, radio, and health staff were three major sources of information from which people learnt about HIV/AIDS. Proportion of respondents receiving HIV/AIDS information from these sources was 46%, 45%, and 33%, respectively. Only around 16% respondents learnt about HIV/AIDS from newspapers, posters, pamphlets, and friends. Less than 10% got to know HIV/AIDS from other sources: magazines, their relatives and their spouses.

Figure 7. Sources of information on HIV/AIDS



IV. Discussion and Recommendations

IV. 1. Overall assessment

The survey had provided a snapshot of ethnic groups in four communes where the project *"Strengthening bilateral cooperation between Nghe An province (Vietnam) and Xieng*

Khoang province (Laos) in HIV/AIDS prevention" would take place. Several factors influencing people's attitudes and behaviors towards their own health had been explored.

In general, traditional culture and religion were not important factors affecting people's health behaviors. Language and illiteracy are still barriers preventing local residents from accessing media or information on health or HIV/AIDS. However, lack of electricity restricted people from mass media and information.

Health care infrastructure was quite adequate with a network of commune health centers in every commune, staffed by nurses and midwifes, and village health workers in every village. Villagers often sought advice from health workers or went to commune health centers when they had severe health problems. However, access to health services was still a challenge due to transport difficulties from remote villages, and high-cost medical treatment was another important problem.

HIV prevention efforts were rather weak and fragmented – these had been loosely integrated with other health care programs, except for the pilot project run by SHAPC. Lacking special counseling and testing services lead to the fact that all 10 HIV cases of Ky Son had been detected by chance, through military recruitment screening.

Certainly, if more people could get counseled and tested, they would find themselves at risk of HIV infection. Using drugs had been common for many local residents since they used to plant opium. When opium plants were destroyed under the government's policy, many drug users shifted from non-injecting to injecting. As the contemporary Vietnamese laws considered drug use illegal, drug users became a hidden population that was affected by a discriminatory attitude of the general population. This reality and the poor access to clean syringes/needles pushed drug users to dangerous practices.

Regarding HIV/AIDS knowledge, both qualitative and quantitative assessments had shown that HIV/AIDS related matters had been inadequately understood. There was a significant gap in HIV/AIDS knowledge, leading to widespread confusion and misunderstanding on how HIV was transmitted and not transmitted, and how to prevent HIV infection. Many people believed that only drug users and sex workers were at risk of contracting HIV, while 'ordinary people' were not. Likewise, people tended to think that only injecting illicit drugs could transmit HIV while injecting medicines would not.

Providing injections was quite a common practice of commune and village health staff, but they had not received any formal and intensive training on safe injection and safe disposal of sharp objects in the context of HIV pandemic.

The most vulnerable to HIV/AIDS communities should be villages that had high numbers of drug users, and/or located along the road number 7, where there was an increased interaction with migrants, cross-border traders, truck drivers, or IDUs from other districts or provinces. H'Mong groups which concentrated mostly in Nam Can commune had the lowest level of understanding on HIV/AIDS and thus could have the highest risk of HIV/AIDS infection.

IV. 2. HIV/AIDS prevention activities proposed by local people

During the group discussions and in-depth interviews, local authorities had shown their great interest and enthusiasm by contributing a lot of ideas on how to effectively prevent HIV/AIDS for their community. In general, they had a common idea that effective HIV/AIDS prevention required a multi-sector collaboration of local authorities, health personnel, social organizations, local residents, and drug users themselves.

1. Multi-sector collaboration

> *"Local authorities are in charge of administering and monitoring preventive activities; social organizations need to collaborate closely with authorities. There is a district HIV prevention steering committee including representatives of local authorities, Youth Union, Women Union, health sector, culture and education sector, and border keepers. The steering committee assigns tasks to each sector or organization to carry out the propaganda activities according to geographical areas, population segments, or age groups. Content and display of these activities should be appropriate to each target group. First priority should be paid to youths, roadside ethnic minority communities, and the Nam Can border gate. Mobilizing the participation and cooperation of village leaders, chieves of strains, and highly-prestigious people in the community is also important" (FGD – district officials).*

Youth Union was and would be the core force for disseminating information on HIV prevention to youths. It was commonly agreed that propaganda activities should include

talks or group discussions covering HIV/AIDS topic. Public activities such as music or singing performances, competitions, or short plays addressing HIV/AIDS should be organized. IEC printed materials – leaflets, booklets – would be very effective tools to improve young people's knowledge.

Women Union was very active in providing direct education visits to households. Empowering women in the fight against HIV/AIDS should be considered a vital content.

> *"We are interested in participating in these activities. Not all ethnic minority women can understand Kinh properly. Our members come from different ethnic backgrounds and therefore we face no difficulty in communicating with such women. We can educate other women on HIV/AIDS using their own language" (FGD - district officials).*

Cultural and information sector played an important role in all communes' daily life. Its staff had the responsibility to provide official information and develop cultural life of the community. Therefore, they should contribute to the common efforts of HIV prevention.

> *"Holding talks in the language of ethnic groups on the subject of HIV/AIDS should be organized. Video or TV programs on HIV/AIDS, prostitution and drugs need to be developed and broadcast twice per week. Video tape would be provided to each village leader who manages a TV /video set to show for other villagers" (FGD – district officials).*

An important task of the society was to have young generations brought up healthy in all meanings of this word. The district boarding school of course bore a glorious position in this regard.

> *"In my opinion, propagandizing HIV/AIDS in schools is the most effective way. The boarding school gathers students from different ethnic groups who speak King fluently. These students when returning home can talk to their relatives who may have difficulties in understanding HIV/AIDS information delivered in Kinh" (FGD – teachers at the boarding school).*

2. Participation of drug users

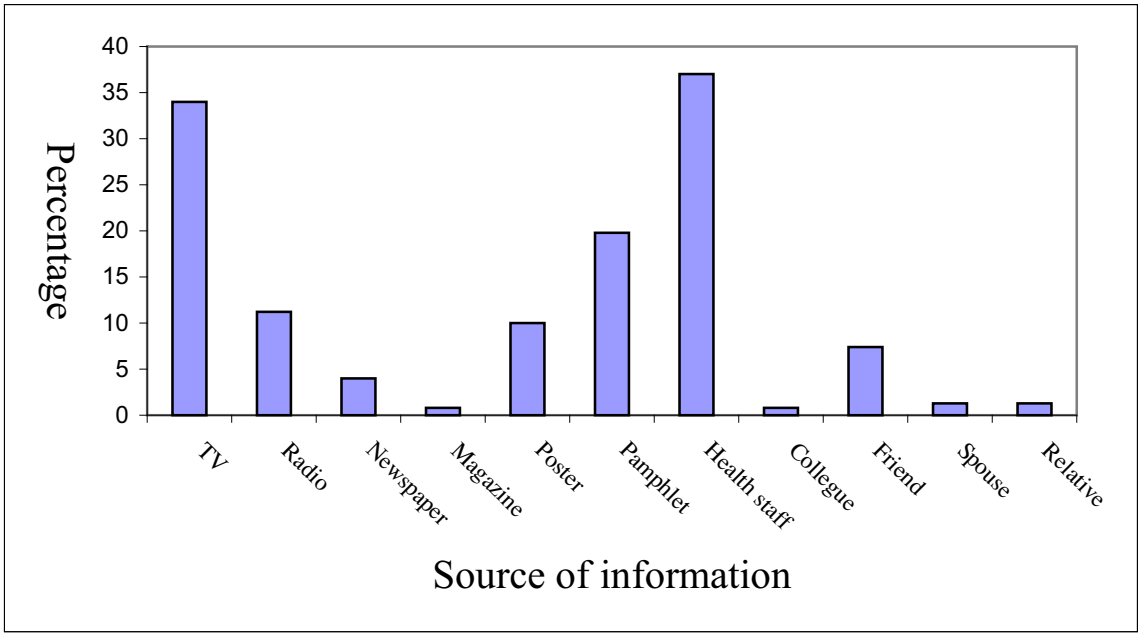
Since drug was considered a social evil, majority of the population had a discriminatory attitude towards drug users. Drug addicts often hide their status, and it was difficult to approach them. Therefore, it would be important to engage drug users who could meet their peers to provide education and to distribute syringes/needles.

> *"Approaching other IDUs, to me, is not difficult. Firstly, I have a variety of relations with the drug using community. Secondly, I am very friendly. Thirdly, I could explain clearly to those who have a lower level of knowledge on HIV/AIDS" (II – 37 year old male drug user).*

3. Sources of information

It was recognized that local people in all 4 communes liked to learn about HIV/AIDS from health staff – 37% respondents considered them as the most useful source of HIV/AIDS information. Television programs occupied the second place with 34% respondents. Leaflets and pamphlets could be useful to 20% interviewees. Around 29% respondents said they wanted to study this matter from other sources such as newspapers, posters, or friends.

Figure 8. Preference to sources of HIV/AIDS information



School activities suggested by local people included opening clubs, competitions, counseling, distribution of IEC materials, etc.

> *"To create a youth club such as adolescent reproductive heath club, question and answer (Q&A) competitions, HIV counseling, distribution of leaflets, booklets, extra-curriculum classes, video shows on HIV/AIDS prevention" (FGD – teachers at the district boarding school).*

IV. 3. Recommendations

Given a variety of factors that could lead to the widespread transmission of HIV ethnic communities in Ky Son, and the cross-border transmission of HIV between Ky Son and Laos, this project *"Strengthening bilateral cooperation between Nghe An province (Vietnam) and Xieng Khoang province (Laos) in HIV/AIDS prevention*" proved to be highly relevant.

The first prioritized group should be young people, as most IDUs belong to this group. Key prevention activity should be improving knowledge and promoting behavior change which targets the general population including drug users. Provision of clean syringes/needles, and condoms, is needed to facilitate behavior change. Moreover, the risk of cross-border transmission obviously requires fostering collaboration between two countries' localities along the borderline.

Following are some specific recommendations:

1. Information provision and behavior change activities

All communities and individuals, including drug users, should be provided with adequate knowledge of HIV/AIDS, recognition of their own risk behaviors and prevention methods, such as condom use and safe injection.

IEC materials should be available in various forms, such as posters, pamphlets, panels, TV spots or radio broadcasts to support behavior change. To facilitate people from ethnic groups, cassette tapes on HIV/AIDS prevention should be produced using their own

languages. It is recommended that video tapes carrying HIV/AIDS messages developed for ethnic groups so that they could watch using available video players.

It is very effective to distribute printed materials with attractive illustrations to each household, to help cover the gap of their geographical distance. Pamphlets with questions and answers on HIV/AIDS would be suitable for youths and school students; music performances and competitions on HIV/AIDS prevention are also activities that young people like. Incorporating HIV prevention messages aiming at raising awareness into public events should also be done to attract a large number of local audiences.

Extent of interventions plays a critical role in bringing about effectiveness to the project. There will be very limited impact if only a small proportion of the population could access the project. Therefore, it is critical to do outreach work by visiting households to provide direct education. This activity would involve community leaders, health staff, members of Women and Youth Unions, and drug users in a network of outreach workers and peer educators. An intensive training on HIV/AIDS, communication and counseling skills for peer educators/outreach workers is needed.

2. Safer injection and safer sex

Community-wide safe injection campaigns need to be carried out to enhance the knowledge, to promote safe injection practices among the general community and health personnel, and to help IDUs reduce their risks of HIV infection. IDUs want to get or buy syringes/needles from commune health centers or village health workers, therefore these should be made available there. Outreach worker and peer educator network is also very helpful in distributing syringes/needles to IDUs, increasing their access to safe injection.

Besides, in the context of highly potential HIV transmission via sexual contacts, safer sex education and condoms should be made available to the local community.

3. Target villages

The project should spend more efforts to some selected villages with high number of drug users, and to road-side communities where there is an intensive interaction between local residents and mobile populations (migrant workers, cross-border traders, long distance

drivers, etc.) Chieu Luu commune should be paid special attention given the fact that it has the highest number of IDUs and detected HIV cases.

4. Collaboration between two sides of the borderline

Cross-border collaboration is an indispensable component of any HIV/AIDS prevention program in general and of this project in particular. Based on the results of a cross-border workshop that would take place during the project implementation, details of the collaborative action plan will be elaborated.

Border dynamics and AIDS: The case of Vietnam

Nguyen Tran Lam[1]

ABSTRACT

Despite significant efforts to combat AIDS, Vietnam has acknowledged rapidly increasing levels of HIV infection during the last fifteen years. The first case of HIV in Vietnam was recorded in 1990 when the country entered the transition period to a market economy. While the economic reform has brought in their wake an increase of living standards and poverty, it also created new lifestyles and behavioural patterns, and most significantly, new economic and social relations. This socio-economic change has shaped the fertile context for the rise of drug use, prostitution and AIDS in the country, in particular the border provinces. Like Burma, China, Thailand, and Malaysia, Vietnam has been experiencing serious HIV epidemics among injecting drug users, who formed the initial basis for the national HIV epidemic. Drug use patterns among Vietnamese have changed in line with the changing dynamics of drug production and consumption in the Mekong region. Drug abuse and trafficking is accompanied by the growing commercial sex industry and increased mobility and migration, which in turn are significant contributing factors to the spread of HIV/AIDS in Vietnam. The aim of this paper is to provide an in-depth picture of the dynamics involved in drugs, sexuality and the spread of HIV/AIDS in three changing border areas between Vietnam - China, Vietnam - Laos, and Vietnam -Cambodia. Based on various papers, published and unpublished reports, studies and my own interviews, field notes, and observations conducted at the border areas during 2002-2004, the paper is structured in terms of four broad sessions: (1) a description of the transborder issues as a macro context for the AIDS epidemic; (2) an analysis of the trends in the sexual and drug-taking behaviours that facilitate the transmission of border HIV; (3) the HIV vulnerability of some ethnic minority people living in border areas; (4) the conclusion highlights the importance of taking into account the social and historical aspects that shape the transmission of HIV at the borders.

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Factors Related To Sexual Risk Behavior for HIV Infections Among Myanmar Migrant Fishermen In Ranong, Thailand

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ABSTRACT

This cross-sectional study aimed to describe sexual risk behaviour for HIV infection among migrant fishermen in Ranong, Thailand.

Between January and February 2004, 159 migrant fishermen from 15-49 years of age in Muang district, Ranong, Thailand were asked to complete a face to face structured interview on sexual risk behavior for HIV infection and related factors.

The results showed that all respondents' nationality was Myanmar**,** which consisted of six ethnic groups such as Burmese (53.5%), Dawei (17.0%), Mon (17.0%), Myeik (5.7%), Karen (5.0%), and Rakhing (1.8%). 81% of respondents were under 25 years old and nearly one-third were married or living with sexual partners. Most respondents (81.8%) had education at primary and secondary school. Just under 65% had had sexual intercourse during the past 12 months. Of these, two-thirds reported that they had consistently used condoms when having sex with sex workers. These respondents were more likely to know that condom use and having only one uninfected faithful sex partner could protect them from HIV, and more likely to know how to obtain condoms from pharmacies than the respondents who inconsistently used condoms with sex workers. In addition, only about one half of the respondents reported that clinics or hospitals were available for STI treatment near their boat's berth or their residence. Over 40% of those respondents who inconsistently used condoms with sex workers reported that they had tried addictive drugs during the past 12 months.

It is recommended that new HIV intervention should target migrant fishermen and distribute understandable information and knowledge of HIV/STI prevention. Local clinics, hospitals and pharmacies (drug store) should provide better STI/HIV prevention and care services for migrant fishermen. Drug abuse among migrant fishermen calls for further study.

KEY WORDS: IGRANT FISHERMEN / SEXUAL RISK BEHAVIOR / HIV

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INTRODUCTION

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) has become one of the big issues globally (1). In Thailand, HIV/ AIDS has already emerged as serious public health and social problems. Sexual contact transmission is responsible for 82.2 percent of HIV infection (2). Taking safer sexual behavior can reduce the vulnerability of HIV infection (3).

Migrant fishermen have mobile population and migrant characteristics. Migrant workers escaping the chronic poverty in Cambodia and the political and economic situation in Myanmar now constituded the majority of fishermen working in Thailand (4). More than half of the 161,667 registered migrant fishermen were employee (not family member), of whom about 42 percent were documented migrants from either inside or outside Thailand [12,750 from Myanmar (Burma) and Cambodia] (5). Migrant fishermen are primarily between the age of 16 to 30 years olds and generally have low levels of education and literacy (6). They usually work on boats for prolonged period of time—several weeks or years.

Migrant fishermen are vulnerable to STI/HIV/AIDS infection. They often engaged in sexual risk behaviors (7,8,9) when they arrive ashore, since they are young, away from home, separation from culture and social constraints, lower educated, with constant peer pressure, facing risk environment such as alcohol and commercial sex readily available on shore. Visiting prostitutes is as a bonus of their hard work (10). Moreover, migrant fishermen faced some difficulties in accessing to health information or services due to their migrant status and language barriers.

Migrant fishermen in Thailand are one of highest risk groups for HIV infection. Firstly, About 60 percent of the surveyed fishermen had admitted to having multiple partners and visited commercial sex worker while away from home (11). Secondly, they have high prevalence of HIV infection. Cumulative number of AIDS of fishermen is about 1,200, accounting for 1.5 percent of total AIDS cases in Jan. 1998 (2). About 15 percent prevalence of HIV/AIDS in 2000 is among the surveyed migrant fishers in Thailand (12). Seroprevalence data among fishermen in Ranong reveals alarmingly high levels of HIV

from 7 percent HIV+ in 1991 to 14 percent in 1992 and 22 percent in 1993 (13). The monitoring data in 1998 showed high antiHIV seropostive prevalence (24.5 percent) in fishermen in Songkhla Province in the southern region of Thailand (14), compared to 1.8 percent of estimated adults (15-49) rate of living with HIV/AIDS in the end of 2001 (15). Thirdly, condom usage was low when they have sex with commercial sex workers. A study showed that only about 31.1 percent of the surveyed fishermen practice safe sex by using condom (11). Finally, About 30 percent of fishermen reported that they had ever had a STD in their lifetime in one study in 2001 in Thailand (16).

Ranong province is located in the southeast of Thailand, with long land border to Myanmar. Ranong is also a major port for trawlers destined for Myanmar waters and Indian Ocean ports. There were 5687 registered Myanmar migrant fishermen, accounting for 40.15 percent in total alien population in Ranong in September 2003 (17). As reported, AIDS was the third leading cause of death in 2003 in Ranong (17). There were 721 AIDS patients and Symptomatic HIV/AIDS people and 220 died of AIDS in alien worker group in Thailand-Myanmar border area since 1985. In addition, Ranong HIV sentinel surveillance in December 2002 showed that HIV prevalence was 31.4 percent in Myanmar female sex workers and 6.5 percent in Myanmar migrant fishermen (17).

However, migrant fishermen in Thailand are not aware of the risk for HIV infection (12). There were some rapid assessments of seafarers in larger ports of Ranong, Mahachai, Songkhla and Samut Sakorn province, in seafaring communities in the Mekong subregion and in source communities of 19 provinces in the Northeast Thailand. So far, none of the agencies had effectively undertaken HIV intervention measures among migrant fishermen (10). UNAIDS reported that neither Uganda nor Thailand has collected data on HIV among their substantial forced-migrant populations (15). No study was reported on factors related to sexual risk behavior of HIV infection among migrant fishermen in Ranong, Thailand. Therefore, it is felt deemed necessary to implement research among migrant fishermen in Ranong, Thailand.

This survey investigated factors related to sexual risk behavior for HIV infection among migrant fishermen in Ranong, Thailand. For example, it described sexual risk behavior among migrant fishermen, predisposing factors, enabling factors and reinforcing

factors related to sexual risk behavior among migrant fishermen and identified the relationship between sexual risk behavior and factors mentioned above.

METHODOLOGY

Survey of study subjects

This cross-sectional survey was carried out among Myanmar migrant fishermen at reproductive age (15-49 years old) in selected Muang district in Ranong Province, Thailand, one of Thailand-Myanmar border areas with 6.5 percent of HIV prevalence among 5678 registered migrant fishermen by applying educational and organizational diagnosis of the Precede Model. For sampling, we did mapping first in the Muang district and selected four migrant fishing communities by cluster sampling and then chose 159 migrant fishermen by simple random sampling on sites. During 24 to 29 January and 9 to 14 February 2004, the trained local male health personnel conducted face to face interview individually on ashore. Interview was in settings where others could not overhear questions and answers in order to reduce the likelihood that respondents will give "socially desirable" answers rather than telling the truth. Respondents can communicate with interviewers in Thai. Before question began, interviewers explained carefully the purpose of the study to selected respondents, and obtained their full consent to participate.

Structured questionnaire (in Thai) was used for surveyed in the field. This questionnaire English version was modified from a behavioral surveillance survey questionnaire for adult target groups aged 15-49 of Family Health International 2000 (18), which was applied for behavioral surveillance survey among seafarers/fishermen in Vietnam 2000 (19) and Lao PDR 2000-2001 (20). And survey of partner relations and risk of HIV infection in 1990 in Thailand (21) was taken as reference. As we know, the BSS of FHI is typically used with adult occupational group such truck drivers and seafarers, and BSS's questionnaire asks respondents to report sexual history on their regular (cohabiting or spousal) sexual partners, commercial (paid) sexual partners (CSW) and other non-regular partners in the past year. And it asks respondents to report last time and consistent condom use for each of these partner categories. The questionnaire in this study reduced the questions on sexual history in BSS of FHI from 27 to 6. Most questions of the questionnaire in this study focused on factors related to sexual risk behavior and added many new

questions such as job position, accessibility to CSW and peer influence, etc in order to fit objective of the study and the setting of migrant fishermen in Ranong, Thailand.

Statistical analysis

Univariate analysis: Described the distribution of single variable by number and percentage. Bivariate analysis: Pearson Chi-square test assessed the relationship between categorical variables. The fisher exact test was applied when n was less than 20 or if n was between 20 and 40 and one of the expected frequencies was less than 5. Epi info 6 program was used to calculate p-value. Statistical tests were two-tailed and interpreted at 5% significant level.

RESULTS

Between January and February 2004, 159 migrant fishermen from 15-49 years of age in Muang district, Ranong, Thailand were asked to complete a face to face structured interview on sexual risk behavior for HIV infection and related factors.

Univariate analysis showed that respondents were quite young. Of 159 respondents, 129 respondents' (81.1%) age was under 25. Minimum age was 15; maximum age was 48; median age was 21. In relation to marital status, only 32.1 percent of them were currently married or living with sexual partners. With respect to education, most respondents had lower education level. 47.8 percent attended primary school; 44.0 percent finished education in secondary school of the Myanmar education system. In this study, all respondents' nationality was Myanmar, which consisted of six ethnic groups such as Burmese (53.5%), Dawei (17.0%), Mon (17.0%), Myeik (5.7%), Karen (5.0%), and Rakhing (1.8%). Job position of respondents indicated that most respondents held position in crewmember (85.5%) and fishing net master or assistents (10.1%). Only 4.4 percent were foremen (captain) or assistant.

The study indicated that nearly all respondents (98.1%) had heard of HIV/AIDS before. 48.4 percent of them knew someone infected with HIV or died of AIDS. 30.2 percent reported that they had close friends with HIV/AIDS. 86.2 percent of respondents knew that condom use can protect themselves from HIV; 73.0 percent knew that having only

one uninfected faithful sex partner can be one of HIV prevention method. 87.4 percent had knowledge on sharing syringe in injection having more chance to be infected HIV. In addition, 75.5 percent acknowledged that infected pregnant women can tranmit HIV virus to her unborn child. However, only 44.0 percent of respondents anwered that abstaining from sexual intercourse can protect themselves from HIV. 54.7 percent answered that HIV/AIDS infected women can transmit HIV virus to her newborn child through breastfeeding. 22.0 percent recognized that antiretrovirals can be used for a pregnant woman to protect her unborn child from HIV. Wrong belief about AIDS transmission also still existed among respondents. Almost every respondents (98.7%) believed that HIV can be transmitted by sharing a meal with HIV infected person. Only 22.0 percent of them held right belief on person not getting HIV from mosquito bites; 25.8 percent believed that HIV infected person can be healthy looking.

The survey showed that 82.4 percent of respondents had drinks containing alcohol during the past 12 months. Frequency of alcohol use was not quite often. Only 22.9 percent drank two or four times a week. Most respondents (77.1%) drank alcohol once a week or less. Regarding drug use, no respondents reported to have tried injecting addictive drugs using a syringe. 27.7 percent of respondents had tried addictive drug during the past 12 months.

The study found that it is quite easy for respondents to access to CSW. 72.3 percent of respondents reported that they can easily find commercial sex worker near residency or docking. Nearly all respondents had expericence of long-distance travel out of Andeman Sea during the past 12 months. 47.2 percent of respondents had heard of commercial sex services on mobile boat at sea. However, only 5.3 percent of those who had heard of commercial sex services on mobile boat at sea had used this commercial sex services. Regarding peer influence, most respondents those who had sexual intercourse and visited CSW during the past 12 months visited CSW in group. Only 2.8 percent went to the brothel alone. In addition, they reported that almost all their friends (98.6%) visited CSW; 35.2 percent of them reported that their friends asked them go to the brothel.

For condom avaiability, among 75 condom users, 44.0 percent knew that they can buy condoms at drug store (pharmacy); 18.7 percent of condom users knew that they can obtain

condom from friends. 33.3 percent reported that they can get condoms from sex workers. The time of obtaining condoms was not too long. Almost every condom users can get condoms within one hour. 26.7 percent reported that they can obtain condom at once. No reported knowing to obtain condoms from conveinent shop (7 Eleven), market, clinic, hospital, family planning center and peer educator.

Regarding STI experience , availability of STI care services, and health intervention, 3.1 percent reported a genital discharge; 5.0 percent reported a genital ulcer or sore during the past 12 months. 49.1 percent of respondents reported that a clinic or hospital was available for STI treatment near their docking or residency. 71.1 percent of respondents reported that they had seen information about HIV/STI prevention around residency; 30.8 percent had seen peer education activities around residency. Only 10.2 percent of respondents who had seen peer education activities attended the peer education activities for HIV/STI prevention or condom use.

In respect to sexual risk behavior, 103 respondents (64.8%) had sexual intercourse during the past 12 months. Among them, 65 respondents (63.1%) reported having sex with sex workers during the past 12 months. Of 65 respondents who had sex with sex workers during the past 12 months, 43 respondents (66.1%) reported that they consistently used condoms, 22 respondents (33.9%) inconsistently using condoms. Consistent condom usages of respondents with non-regular partners and regular partners were 43.4 percent and 25.0 percent, respectively. Among 22 surveyed respondents who inconsistently used condoms with CSW, 19 respondents had sex with non-regular partner; 18 respondents reported that they inconsistently used condoms when they had sex with non-regular partners. There were similar situations in regular partners.

Bivariate analysis indicated that respondents who consistent used condoms with sex workers were more likely to know that condom use and having only one uninfected faithful sex partner can protect themselves from HIV than respondents who inconsistent used condoms with sex workers ($p<0.05$); more likely to have knowledge about HIV/AIDS infected women transmitting HIV virus to her newborn child through breastfeeding ($p <0.05$); more likely to know to buy condoms at pharmacy (drug store) ($p<0.05$); and more likely to have seen information about HIV/STI prevention around residency ($p=0.052$). 40.9

percent of respondents who inconsistently used condoms with CSW reported to have tried addictive drugs during the past 12 months. However, the significant difference was not identified in foremen and crewmember (or fishing net master), familiarity of HIV/AIDS, alcohol use, drug abuse, and peer influence between inconsistent condom users and consistent condom users with CSW.

DISCUSSION

Sexual risk behavior: Situations on HIV/AIDS have improved much among fishermen in Ranong. The HIV prevalence of fishermen in Ranong droped down from 22 percent in 1998 (10) to 6.5 percent in 2002 (17). Inconsistent condom usage with CSW in the study was 33.9 percent, which was lower than 68.9 percent among fishermen in the Gulf of Thailand and the Andaman Sea in 2001 (16). However, Ranong HIV sentinel surveillance in December 2002 showed that Myanmar female sex workers had 31.4 percent of HIV prevalence (17), and among respondents who had sex intercourse during the past 12 months, 63.1 percent reported to have sex with CSW. Also, migrant fishermen were a significant bridge population for transmission of HIV. An overlap of three patterns, having sex with CSW, with non-regular partners, with regular partners, was found in this study. This was one of major risks to be infected HIV (22). Reducing the number of sexual partners overall, avoiding anonymous sexaul partners are behaviors that reduce risk of HIV infection.

Socio-demographic characteristcs: Age: Since one of objectives of the study is to describe sexual risk behavior, age of respondents in this study was set at reproductive age (15-49 years old). Results of the study showed that respondents were quite young. 80 percent of them were under 25 years old. The reasons may be due to occupation characteristics of fishermen. Fishermen had hard work. Migrants can easy find job as fishermen in Ranong (4,5,6). The age range are known to be sexual active and risky taking. The average age of the surveyed fishermen in one study was less than 30 years old (12). This study showed that age range of respondents who had sex with CSW was 16 to 30. Thus they were considered to be most vulnerable group for HIV infection. Education**:** Education could help to increase the knowledge of adolescents about HIV and has been found modifying their attitudes and intentions to practice HIV preventive behavior in some extent (23). The study showed that respondents had primary or secondary school education

status in the education system of Myanmar and the significant difference was not identified in education level between inconsistent condom users and consistent condom users with CSW. This may suggest that information about HIV/AIDS/STI prevention and care service should be adjusted to be understandable and acceptable for migrant fishermen as well as the technique and means for transfering knowledge should be appropriated, especially in terms of simple language and directly education method. Nationality and ethnicity: Nationality of all respondents was Myanmar. Respondents came from six ethnic groups, such as Burmese, Dawei, Mon, Myeik, Karen and Rakhing. Immigration status of migrant fishermen and migrant policy of Thailand government affected attitudes and practices of sexual risk behaviors among migrant fishermen. Language barrier was one of big obstales for migrant fishermen to reach local health intervention and HIV/STI care services as well as health education media. Job postion: The work status determined the level of income that would affected the style of living, personal health behavior and choices of service. Some studies on migrant fishermen in Thailand (4,10) found that both crewmeber and captian had sex with CSW. The difference in two groups was to choose different sexual services. The study found that among respondents who had sex with CSW, the significant difference was not identified in foremen and crewmember (or fishing net master) between inconsistent condom users and consistent condom users.

Knowledge and information of HIV/AIDS: A quatitative study among seafarers in Northest Thailand (6) reported that perceiving close friend's die of AIDS changed seafarers' attitudes and reduced practices of sexual risk behavior with CSW. However, in this study, the significant difference was not identified in familiarity of HIV/AIDS between inconsistent condom users and consistent condom users with CSW though 30 percent of respondents resported that they had close friends with HIV/AIDS. A study conducted by Pimonpan Isarabhakdi (24) showed that the more knowledge about HIV infection prostitute's patrons has, the more likely they use condoms consistently. The results of this study showed that respondents who consistently used condoms with CSW were more likely to know that condom use and having only one uninfected faithful sex partner can protect themselves from HIV than respondents who inconsistently used condoms with CSW ($p < 0.05$), more likely to have knowledge that HIV/AIDS infected women can transmit the virus to her newborn child through breastfeeding ($p<0.05$). Meanwhile, the result showed that knowing rate of some questions was still lower. For example, half reported that

abstaining from sexual intercourse can protect themselves from HIV, and HIV/AIDS infected women can transmit HIV virus to her newborn child through breastfeeding. Only 22 percent recognized that antiretrovirals can be used for a pregnant women to protect her unborn child from HIV. In addition, wrong belief about AIDS tranmission existed widely among respondents. This may suggest that knowledge of HIV prevention was effective for taking safer sexual behavior such as consistently using condoms to prevent HIV infection and lots of work should be done to improve knowledge and information of HIV among migrant fishermen in Ranong.

Alcohol use: Alcohol has been implicated as a "gateway" drug, which leads to impaired judement and sexual risk behaviors. In this study, only 22.9 percent of respondents drank alcohol two to four times a week in the past four weeks. The significant difference was not identified in alcohol use between inconsistent condom users and consistent condom users. This may indicate that alcohol use could not be main factors for sexual risk behavior among respondents.

Drug use: AIDS is associated with sexual behavior and drug abuse (25). Drug abuse among fishermen was reported before (18, 26). Some drugs could cause migrant fishermen to be more vulnerable to HIV/AIDS. In this study, no respondents reported injecting addictive drug with a syringe. But, 27.7 percent of respondents reported that they had tried addictive drugs during the past 12 months. And 40.9 percent of respondents who inconsistently used condoms with CSW reported to have tried addictive drugs during the past 12 months. This may suggest that addictive drug using could be one of reasons for enhancing sexul risk behavior among respondents who had sex with CSW. The information derived from this survey is sufficient to call for education/ prevention activities among migrant fishermen. Also there is need to do a further in-depth study on the magnitude of drug abuse among larger samples of these populations.

Accessibility to CSW: One study showed that sex industry in the port city presents strong and with the highest level of HIV infection among fishermen and general population (e.g. pregnant women) (27). In this study, most respondents reported that it was easy to find commercial sex workers near residency or docking or at sea. And 97.2 percent reported that they went to the brothel with friend. However, only 5.3 percent of those respondents who

had heard of commercial sex services on mobile boat at sea reported that they used this services. And there was not significant difference in accessibility to CSW by condom use among respondents who had sex with CSW during the past 12 months. This may suggest that accessibility to CSW around Muang district, Ranong could not be a key factor to affect condom use among respondents.

Availability of condoms: A key public health strategy against sexual transmission of HIV and STIs is the provision of the high quality, low cost condom to sexually active people and the creation of supportive social environment to encourage their use through active promotion. The study showed that the main sources to provide respondents with condoms were pharmacy (drug store), sex worker and friend; and respondents who consistently used condoms with sex workers were more likely to know to obtain condoms at pharmacy (drug store) than respondents who inconsistently used condoms with sex workers ($p<0.05$). This may suggest that pharmacy (drug store) should be enforced as one of main outlets for condom promotion and HIV/STI information distribution.

STI experience: There is already evidence that a previous history of sexually transmitted diseases (STDs) could stimulate some interaction between various organisms and HIV through genital breaks. The study showed that about 3 to 5 percent of respondents reported STI experience during the past 12 months, which was lower than 31.1 percent of STI history among fishermen in the Gulf of Thailand and the Andeman Sea in 2001 (16).

Availability of STI care services: In the study, only half respondents reported that clinic or hospital was available for STI treatment near docking or residency. It was reported (10) that the regulation of Thai government agency in no way ensured that migrant workers received benefits, such as seafarer access to medical services. In Ranong, the provincial public health department and Ranong hospital can not provide both prevention and care services to migrants since its budgets was calculated on the basis of the official resident population. This may raise an issue about improvement of health service and health policy for migrant fishermen in Ranong.

Health intervention: Behavior interventions are currently the only effective way of slowing the spread of HIV infection. Recent research indicated that aggressive promotion of

safer sexual behavior and prevention of substance abuse could avert tens of thousands of new HIV infection and potentially save millions of dollars in health care costs. HIV prevention requires efforts at the level of individual, couples and family, community, and law and policy. The results of study showed respondents who consistently used condoms with sex workers were more likely to have seen information about HIV/STI prevention around residency than respondents who inconsistently used condoms with sex workers ($p=0.052$). This may suggest that distribution about HIV prevention information was one of effective methods for condom promotion among respondents. However, the study showed only 30.8 percent of respondents reported that they had seen peer education activity around residency. Among them, 10.2 percent reported that they attended peer education activity for HIV/STI prevention or condom use. At present, partnerships between government, NGOs, community organizations and business sector seem inadequate to bring about the desired reduction in infections among migrant fishermen (4,10). Therefore, new HIV interventions should be carried out to target migrant fishermen through peer education, sex /reproductive education, life skills training etc. Promoting condom use in all sexual relationship is a major health intervention method, and efforts should be launched to improve the availability of condom for migrant fishermen.

Methodological issues: This study tried to explore factors related to sexual risk behavior of HIV infection among migrant fishermen in Ranong, Thailand by applying educational and organizational diagnosis of the Precede Model. Face to face interview was conducted because most migrant fishermen had lower education status. In order to reduce the language barriers, and get the true answer to the sensitive question, we trained male local health personnel as interviewers. Respondents in Muang district can communicate with interviews in Thai. Before questioning began, interviewers explained the purpose of the study, and obtained the respondents' full consent to participant, reducing refusal bias. With respect to the instruments, the questionnaire was modified from HIV/AIDS/STIs behavioral surveillance survey questionnaire (2000) of Family Health International (18), which was applied for behavioral surveillance survey among seafarers/fishermen in Vietnam 2000 (19) and Lao PDR 2000-2001 (20). A similar questionnaire for survey of partner relations and risk of HIV infection in 1990 in Thailand (21) was taken as a reference. The questionnaire Thai version was used for survey in the field. For the study quality control, Ranong Provincial Deputy Chief Official well organized the survey.

Interview was done during 24 to 29 January and 9 to 14 February 2004 when respondents were on shore. Quality of questionnaires was good. No data missing and answers of questions were consistent logically.

This study was conducted in Ranong, Thailand and sample size was small. So, the result can not be generalized to migrant fishermen in the whole country. We did not have chance to conduct focus group discussion and in-depth interview for further analysis, such as collecting detailed community-level data on social, culture and economic organization, and family-level data on sexual behavior. Data collection was difficult. Since limit time for survey and insufficient financial resources, we actually collected 159 questionnaires instead of planed 198. Now some interesting results of the study should be identified in further research.

CONCLUSION

Main findings of the study are as follows: Firstly, respondents reported very high sexual risk behavior. Among respondents who had sexual intercourse during the past 12 months, about 63.1 percent reported to have sex with sex worker and about 33.9 percent of them inconsistently used condoms with CSW. The study also showed that migrant fishermen were a significant bridge population for HIV transmission. An overlap of three patterns, having sex with CSW, with regular partners and with non-regular partners, was found in this study. Secondly, kknowledge on prevention of HIV and possibility of infecting HIV correlated with consistent condom use. Respondents who consistently used condoms with CSW were more likely to know that condom use and having only one uninfected faithful sex partners can protect themselves from HIV than respondents who inconsistently used condoms with CSW ($p<0.05$). Moreover, distribution of HIV prevention information showed effect on condom use among respondents. Respondents who consistently used condoms with CSW were more likely to have seen information about HIV/STI prevention around residency than respondents who inconsistently used condoms with CSW ($p=0.052$). Thirdly, the study showed that it was not easy for respondents to access to local STI care services. Only half respondents reported that clinic or hospital was available for STI treatment near docking or residency. In addition, Pharmacy (drug store) was one of main places for obtaining condoms. Respondents who consistently used condoms with CSW

were more likely to know to obtain condoms from pharmacy (drug store) than respondents who inconsistently used condoms with CSW ($p<0.05$). Finally, Drug abuse rang an alarming bell among migrant fishermen. 40.91 percent of respondents who inconsistently used condoms with CSW reported to have tried addictive drugs during the past 12 months.

Recommendation for actions: Based on above findings, new HIV intervention should target migrant fishermen. Understandable HIV/STI prevention information and knowledge should be distributed further among migrant fishermen. Better health prevention and care services including STI care services and condom promotion should be provided to migrant fishermen through local clinic, hospital and pharmacy (drug store). Myanmar government agencies and Thai government agencies, recruiting agents should oversee and participate the HIV intervention program which include delivery of necessary services and provision of medical officers and staff who speak the native languages used by migrant fishermen in Ranong, reduce of migrant fishermen vulnerability to HIV through providing an institutional and enabling environment for behavior change. Meanwhile, an industry workplace policy should be developed through working directly to pier and boat owners. Advocating collaboration includes cost-benefit aspects of prevention, documenting, and promoting case studies of ‘good practices’, promoting individual philanthropy, providing community responsibility awards, and identifying clear and specific organizational networks between Myanmar and Thailand that could be linked up with HIV/AIDS initiatives.

Recommendation for further study: The information derived from this survey is sufficient to call for education/ prevention activities about drug abuse among migrant fishermen. Moreover, there is need to do a further in-depth study on the magnitude of drug abuse among larger samples of these populations. Sample size could be increased to further identify factors related to sexual risk behavior among migrant fishermen. Focus discussion and in-depth interview could be arranged for research.

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Comparing lifestyle for health of People in the Lower Mekong River Basin

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Abstract:

The objective of this research is to describe the lifestyle of people in the lower area of Mekong River Basin. Research took place in two cities: Mukdahan Province in Thailand and Kunthaburi in Lao PDR. The criteria for field site selection was based on the fact that they are the twin cities which share a similar culture, environment, way of life, history, and locating on the bank of the Mekong River. The sample groups of people were collected by purposive sampling methods (Yamane, T., 1973). Descriptive statistics, including frequency, percentage, mean and standard deviations were used and a t-test was used for comparison between means of different groups. The findings, which compare the differences in health of the two cities, will be used as an example for solving health and mental problems according to a healthy city concept and sustainable development, especially in terms the broader environment in which people inhabit that subsequently affected health. The environmental aspects in daily life that impacts on health are as follows:

1. food consumption;
2. Tobacco, alcohol, and drug consumption, and toxic substance contamination;
3. Dental health, and traffic;
4. Work, exercise and recreation;
5. Family and society;
6. Sexual relationship.

The results and recommendations will be used for international planning among Mekong Basin River countries and communities in the future.

Key words: Compare/ Lifestyle for health / People

Introduction

Thailand like various other countries in the world, was previously a rural based society. However, at the present time, rural areas all over the world are changing tremendously because cities and towns are increasingly becoming the source and center of economic and social activity. Therefore the state of city has tendency of expanding to the

rural areas more and more. From the forecasting of world population of United Nations that at the middle of the year 1900, there was 2.7 billion people or 45% of the world population would live in the city. The population of under developing countries with 1.5 billion people or 37% of them lived in the city. In the developed countries, 0.9 billion or 73% of them lived in the city. Two third of world population were in the under developing countries.[1] With this state of high density of city population, a variety of countries have fallen in the crisis of situations of physical and economic environment. In addition, the natural resources have degraded for building shelters or business purposes in order to response the human demands. Ecosystem has been disturbed by the soil, water, air pollutions, and waste accumulation. Moreover, the safety from accident, safety of life and property, social problem, crime, and health problem are deficient.

Healthy City Project occurred from the stimulation of World Health Organization (WHO). The Concepts of healthy city from the 11 countries in Europe in the year 1976 were introduced and expanded to more than 1,600 cities in other regions all over the world with the emphasizing on the physical, social, economic, politic, cultural, and other aspects. These were developed together with the health promotion at global level by using the term of "Health Promotion". "Healthy city" was used by WHO that meant the health city or healthier city or Hygiene city. Therefore, Healthy refers to a state of complete physical, mental and social spiritual well-being, not merely an absence of disease and infirmity. The healthy city concept is integration of health and the international movement on conservation of environment and natural resource and rehabilitation of global environment (Agenda 21_Rio de Ja Nairo, 1976).

Health problems of citizens vary according to the state of environmental change. From the past the illness and death had the causes from the speedy epidemic of contagious disease. When the situations of economic and social changes in term of agricultural society to industrial society, it rapidly entered to the age of globalization. The citizen are in the unreadyness to live in accordance to the state of change so it affects to health problems all of individual, family, and society. At the whole view, the first cause of illness and death were caused by the people and social behaviors, and the second cause were the environmental factors. These results are congruent to the study of Webster that studied on

the factor causing death before expectancy of life. The finding indicated that behavioral factors of that person with 53 percents, the environmental factor with 31 percents, and 16 genetics and biomedical factors. Webster concluded that everyone should change and improve their behaviors or lifestyles together with the promotion of environmental state to be in good, clean, and safe from all pollutions[2]. The situation of environmental problem connects to health problem. The sickness of the population was changing from the state of infection due to the poverty to the non-infectious disease. Therefore, most of diseases occurred from the hygiene behavior. The work aims to implement in proactive form of health building to reach all aspects of health states on physical, mental, social, and spiritual aspects that links together with the unity relation with the closely participation of people. Without omitting to develop the health repair, this makes the people having both quality and potential of physical, mental, spiritual, emotional, and social aspects The scholars pay their attentions behavior in daily life in the aspect of food consumption and excretion, smoking, alcohol, drug and toxic substance. In addition, dental health, car and road uses, work, exercise and recreation, family, social, and sexual relation are the lifestyles for health of population in the Mekong region that are parts of promotion for the healthier city

Literature Review

Lifestyles for health, Luecha Wanarat, (2000.:6-36) [2] mentioned that the factors in the aspect of behavior, and lifestyles of behavioral practice of people of differences of race, ethnic, society, and locality are the delicate and complicated issues. Sometimes, it is difficult to understand the reasons and conditions to cause these behaviors. The perspective of outsiders view from outside that community, particularly, with different race, religion, culture, and language. The thinking system, belief, training, educational, political, economic, and familiar environmental systems are included because these conditions and others are the motivation, stimulation, and obstruction factors that cause people make decision to perform behavior or not in any issues. This is called as behavior of that person. When they regularly and continuously practice until it becomes to be their behavior. Whether they live in any circumstance, it will finally become “Lifestyles” of that person.

There are plenty of daily life behaviors that are commonly practiced and the results of these behaviors are different. It may be satisfaction for the performer or the others or not up to the type of performance. Some behavior merely affects to the actor but some affects to the others and both living and non-living environments. However, there is a group of behavior that whether it is performed or not, it also may affect directly and indirectly to one's or another health with short or long term. This group of behavior is called health behaviors or hygiene behaviors as follows:

1. Consumption and excretion behaviors include the food production, food selection, cooking, preservation, and cleanness maintenance. At Present, it is found that obesity is a risk factor in the western countries due to the over-weight of more than a half of the population whether it is calculated from any indicators. It is obviously seen that the health problem related to over-weight or obesity that are myocardial infraction, diabetes in adult, gout disease, osteoarthritis, hypertension, varicose vein in woman, and endometrium cancer, Moreover there are other indirect diseases such as disease of gallbladder, gall stone in kidney, breast cancer, abnormal menstruation, kidney disease, dermatitis, anesthesia problem, mental problem, hemorrhoid, high uric acid in blood, and diabetes in the primary phase[3]. The prevention is care on the food consumption, exercise according to age and physical state[4]. Excretion of body waste, USA, studied that an American male with the over-weight, has a waste in the intestine about 5 kilograms (At present, it may have more than 5 kilograms of waste in the body since the structure is larger than previous time). People have average of three meals per day. Some between the meals also take the snack. From the research reports, the finding indicated that the person who prefers to take the fat enrich food or meat, they will only excrete 3-4 ounces of stool. The food will take 2-3 day to move from mouth to anus, particularly, in the old age, their digestive system has lower effective; it might take more than 1 week for the food movement. For the person who is fond of high fiber food, he/she will excrete 13-17 ounces of stool per day. The food will take about 20-30 hours for moving from mouth to anus. This means the total amount of food eating in each time will not total excrete in the next day, there is some food left in the intestine and it will ferment in the intestine. The symptom of fermented food accumulated in the intestine will express in different means such as gastritis, suffering from constipation, diarrhea, or abnormal excretion, headache, or insomnia and skin problem for

instance. This is an important cause of sickness[5]. Means to make the large intestine healthier are as follows:

1) Properly chew the food before swallow.

2) Select the food for consumption, and know what is going to be ferment or difficult to digest or high fat or fried food, and what should avoid to consume these high risk of sickness food and one has to take high fiber food contained enrich nutrient for body to control body weight. The food fiber is high in fruit and vegetable. Food fiber will puff up to increase volume of stool that will affect the feeling of evacuation the bowels. While the fiber moves together with food it will sweep the accumulated things or toxic substance in the intestine to go out with the stool. The medical reports revealed that the food fiber has the function of decreasing the risk of colon cancers occurred by the stimulation of accumulated toxic substances[6].

From the studies of food influence towards cancer of nine nations with 400,000 peoples by the professor of nutrition unit of Cambridge University, the head of research team found the group of people who ate the enrich fiber food, they were prevented from colon cancer and descending intestine with 40 percents. The medical experts had ever believed that the people of developed countries can be prevented from cancer with 30 percents if they select to eat the correct proportion of food together with food and vegetable consumption, especially 5 times per day[5].

3) The regularly daily evacuation, and notice how about the evacuation features, its characteristics should be soft, good color, not hard or withered pattern, irregular form or like the seed of jack fruit. In addition, it should be observed that what you take that make you suffer from constipation.

4) The regular exercise will stimulate the movement of intestine effectively.

2. The behaviors of smoking, alcohol drink, drug, and toxic substance, this is a group of consumption behavior that degraded the health such as drinking, alcohol smoking, drug, and toxic substance. For instance, smoking, the substances in the tobacco are including nicotine, tar, carbon monoxide, hydrogen cyanide, nitrogen oxide, ammonia, radio active substance, minerals accumulated in tobacco. Smoking is harmful to health by causing the lung cancer, hard of artery, and artery constriction, and chronic bronchitis for example[7].

3. Behavior of car and road use is a group of behavior of safety travel from the accident such as to practice according to the traffic rules, including to wear safety belt, safety hat, crossing road, selection of transportation, wear the life safe jacket, not drinking while driving and follow the traffic rules.

4. Work behavior, exercise, and recreation, group of behavior of careers of routine work with appropriate force level or moderate level, it will assist to decrease the state of physical degradation. This was reported by Woranan Boonnak, Bongkod Hongkammee, and Jatnapit Rayubkul, (1996)[8]. They studied on the health behavior of career group in the slum community as follows:

1) Every career has the low or high risk that differs according to the characteristics of work of each occupation to cause the sickness.

2) Every career has the mean to protect worker's health, it depends on the knowledge, understanding, belief, and mean of practice in accordance to prior experiences.

3) Behavior of self-care about health, it is still incorrect practice because 57 percents of them with buying the medicine by themselves while 53 percents take the alcohol drinks, and tobacco, stimulant drinks, and drug.

4) Health behavior is not only direct consequence from the occupation but it is also the environment of community and town community both physical and social aspect, and inadequate income. These will affect to health status and cause the stress to every worker.

5) Most of the workers lack the information and knowledge about the self-care health, maintenance of house environment, and inside community. Most of decision making about self-care for health depends on the belief, way of life, and their prior experiences.

6) Insecurity about shelter, the hardship of earning and lack of support from different sectors of government and private related to the occupation that affect to way of life, income, debt, and burden. The proper self-care for every occupation has to depend on their physical and mind power, if they get the support for information on the work of occupation and self-prevention for health care. This affects to development for all problems to be more appropriate and effectively.

For the exercise aspect, it makes the healthier for both physical and mental aspects. The diseases will be often found in the group of people who do not exercise are

hypertension, myocardial infraction, obesity, diabetes, high blood cholesterol, stress, allergic disease, fatigue of muscle, and cancer[9].

Research team of Science and Health of Oregon University in the USA stated that the exercise will aid to stimulate the blood circulation to supply the brain.

It was done in the monkey and it was found that exercise can stimulate the development of blood vessels in brain so this makes the monkey was alert and vital more than the one that does not exercise. It was obviously seen when it was done in the older monkey since the first period of the experiment. They said that the first period of exercise, it affects to make a better hart function, and aid to decease the obesity disease[10].The researcher of Hutchison Center at Seattle city of USA, studied on exercise to expel the insomnia by studying in the women with the age between 50-75 years. The finding revealed that the group of woman who exercise, she will sleep better and easier with the increment of 70 percents[11].

Kline Melanin, professor of exercise subject of Massachusetts University in USA, studied on the exercise should not be done with overtax but one can regular walk, the hart can be strong. From the research is done with 84 middle age of both sex[11].

The group of stress relaxation, Pamela Peeke, the expert from University of Maryland School of Medicine in Baltimore found that the stress affects not only to the mental health but also cause the obesity, particularly, the one who often has the stress or chronic stress, she/he often get weight gain. This symptom can be often found both male and female of the middle age. They will gain more fat than the person with normal emotion or relaxation emotion. Peek said that the technique of relaxation is not enough to get rid of the obesity problem caused by tress. But the best way is to prevent the secretion of Stress Hormone with exercise because during the exercise, the body will produce the Beta Endorphin[12].

6. Family and Social behaviors, the relationship among people within the family and society, human can not live alone. But when they live together, there is a conflict of demand without pertinence and unhaminized thinking. These cause the conflicts that lead to the stress. Way of conflict management among people is as follows[13]:

1) Face with problem when problem occurs, the appointment should be made for adjust the understanding of problem.

2) Hear for the problem of each other without the obstruction.

3) Conclude the occurred problem and evaluate which problem is able to solve to search the conclusion for solving.

4) Search the way to solve when one knows the problem, one will search the problem but one should not hurry to cut off any way but one has to search different ways and consults to the good and bad effect of each way.

5) Respect and practice according to the guideline for selection in order to prevent the next problem.

6) Bring the plan to practice when nobody follows and let one who does not follow to explain in the way that is not aggressive.

7) Revise the agreement, after a practice was done for a passed time, the evaluation must be made whether it is successful according to the plan or not, if not one should start at the first way again.

7. Sexual behavior, and sexual transmitted disease, the diseases will be found in the teenage who has the sexual relation before marriage without the knowledge and understanding about the self-prevention and pregnancy, and sexual transmitted disease. Therefore, the people should have knowledge about contagious disease, symptom of disease, treatment, and facts about sexual transmitted disease[14].

1) The sexual transmitted disease can be infected to every sex, age, and class but it is mostly found in the teenage group.

2) Rate of sexual transmitted disease is highly found because the teenage has the value of living together before marriage or sexual relation at the young age. Another importance issue is the high rate of divorce so it causes people to have wife and husband more than one. Therefore, sexual transmitted disease is increasingly.

3) The sexual transmitted disease does generally not express the symptom, therefore, sexual transmitted disease will be transmitted without awareness of any person. Medical doctors in some countries suggested that it should check for sexual transmitted disease with promiscuous person.

4) The sexual transmitted disease causes a plenty of sanitary problems.

To prevent the sexual transmitted disease, the best way is having no sexual affair, if one still has the sexual affair, one should regard to the safety as follows[14]:

1) Not change the couple, let have only one husband and one wife.

2) Wear condom properly, if one would like to have sexual affair with the unknown person who had infection or not.

3) Not to have a sexual affair when young age because from the statistics, it was found that the high change of infection.

4) Check yearly, for searching the organism, particularly, one wants to marry again.

5) Learn to knowledge of sexual transmitted disease.

6) Avoid having sexual intercourse while menstruation because this state is easy to get the infection.

7) Avoid having sexual intercourse at the anus, in case of emergency, the condom must be used.

8) Avoid washing the vagina because it is easy to get infection.

Behavior or group of behavior, the behavior is properly practiced, it will decrease that man (and the closely people according to each case). One will gain good health but one can not properly practice. This will cause the sickness, or unhappy or unhappy state. It might be threatened to other systems of body.

Methodology

The research design is implemented in steps by step as follows:

1. The preliminary survey was done in order to search the basic information of the population demographic characteristics and lifestyles.

2. The questionnaires were tools employed for collecting and evaluating the behavioral on the lifestyles.

3. The questionnaires were used to determine the reliability of each question and the whole paper was done by determining the alpha coefficient (α-coefficient) (Sproull, 1988).

4. Population and sample, the sample was 60 peoples who live on the bank of Mekong River, Mukdahan Province, Thailand and Muang Kunthaburi, Khang Sawannaket, People Republic of Lao. Sample was collected by accidental technique.

5. The questionnaires, the score was rating into 4 levels as follows:

The most correct practice = 3 scores

The more correct practice = 2 scores

The moderate practice = 1 score

The incorrect practice = 0 score

Interpretation for score was as follows:

Level of scores between 80-120 scores means good health level.

Level of scores between 40-79 scores means moderate health level.

Level of scores between 0-39 scores means health level must be improved.

6. Descriptive statistics, including frequency, percentage, mean and standard deviation will be used and the t-test will be used for comparison between means of different groups. Moreover the Chi-Square test was used for determine the association between demographic data and health status.

Research Results

The characteristic of sample group, Thailand had the mean of age is 43.83 years. Most of them was 50-59 years old with 30 percent, subsequences were 30-39 years with 20percents and 20-30years with 16.7 percent respectively. Most of them was female with 60.0 percents, and the marital status was couple with 63.3 percents, Their education level was at primary school level or lower with 40.0 percents, secondary school or high school level with 36.7 percents. Most of their occupation was merchant with 63.3 percent. Their income mean was 11,298.67 Baht per month. Most of their health status was at good level with 83.3 percents, chronic disease with 16.7 percents that was heart disease with 40.0 percents, toxic thyroid, hypertension, and allergy with 20.0 percents. The evaluation of health status by themselves, most of them were at good level with 46.7, and subsequences was at moderate level with 40.0 percents. For yearly physical check up, most of them were checked with 56.7 percents, when sick, they came to hospital with 60.0 percents. For their interest and study on the health information was few and it depended on the opportunity provided with 60.0 percents. For water for consumption, most of them obtained water from tap water that already treated with 73.3 percents. For toilet use, most of them used the standard toilet with 93.3 percents. Most of them had waste management aspect with 93.3 percents by dropping to the municipal bin with 85.7 percents, self-managed with 14.3 percents, and throw away in the environment with 6.7 percents. For food selection regarding to the advantage for health and safety was 73.3 percents. Most of them had

health state at rather good level. The way of living with the proper mean was 46.7 percents, and subsequence was at moderate level. The way of life should be changed with 43.3 percents, and the low level that needed to control way of life was 10.0 percents. The whole health state was at moderate level.

The characteristic of sample group, People Republic of Lao had the mean of age is 34.87 years. Most of them were 30-39 years old with 40 percents; subsequences were 20-29 years with 30.0 percents and 50-59 years with 13.3 percents respectively. Most of them were female with 53.3 percents, and the marital status was couple with 66.7 percents, their education level was at secondary school or high school level with 66.7 percents, primary school level with 16.7 percents. Most of their occupation was merchant with 33.3 percent and business 23.3 percents. Their income mean was 6383.33 Baht per month. Most of their health status was at good level with 93.3 percents, chronic disease with 6.7 percents that was diabetes and peptic ulcer with equally 50.0 percents The evaluation of health status by themselves, most of them was at very good level with 66.7, and subsequences was at moderate level with 23.3 percents. For yearly physical check up, most of them were not checked with 43.3 percents, when sick, they came to hospital with 56.7 percents. For their interest and study on the health information was few and it depended on the opportunity provided with 40.0 percents. For water for consumption, most of them obtained water from untreated water with 36.7 percents. For toilet use, few of them used the standard toilet with 16.7 percents. Most of them had waste management aspect with 93.3 percents by dropping to the municipal bin with 75.0 percents, self-managed with 25.0 percents, and throw away in the environment with 6.7 percents. For food selection regarding to the advantage for health and safety was 76.7 percents. Most of them had health state at moderate level. The way of life should be changed with 60.0 percents, and the subsequence was having correct way of life. The low level that needed to control way of life was 3.3 percents. The whole health state was at moderate level as presents in table 1.

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic classified according to general characteristics, health, and health service, environment, and health state

Description	Thailand	People Republic of Lao

	Number	Percent	Number	Percent
General Characteristics				
Sex				
- Male	12	40.0	14	46.7
- female	18	60.0	16	53.3
Total	30	100.0	30	100.0
Age				
- ≤ 19	2	6.7	1	3.3
- 20-29	5	16.7	9	30.0
- 30-39	6	20.0	12	40.0
- 40-49	4	4	3	10.0
- 50-59	9	9	4	13.3
- ≥ 60	4	4	1	3.3
Total	30	30	30	100.0

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic classified according to general characteristics, health, and health service, environment, and health state (Continued)

Description	Thailand		People Republic of Lao	
	Number	Percent	Number	Percent
Thai Mean= 43.83 S.D= 17.09 Mod =17 Min=17 Max=83 Lao Mean= 34.87 S.D= 11.14 Mod =28 Min=18 Max=60				
Religion				
- Buddhist	28	93.3	30	100.0
- Christ	2	6.7	0	0
Total	30	100.0	30	100.0
Marital status				
- Single	7	23.3	8	26.7
- Couple	19	63.3	20	66.7
- Widow	2	6.7	2	6.7
- Separate	2	6.7	0	0
Total	30	100.0	30	100.0

Education level				
- Illiteracy	1	3.3	4	13.3
-Primary school level or lower	12	40.0	5	16.7
-Secondary school to high school levels	11	36.7	20	66.7
- Diploma degree level	3	10.0	1	3.3
- Bachelor degree level	3	10.0	0	0
Total	30	100.0	30	100.0
Occupation				
- No occupation	3	10.0	4	13.3
-Agriculture	0	0	5	16.7
- Merchant	19	63.3	10	33.3
- Business	5	16.7	7	23.3
-Governmental, state enterprise, private officer	2	6.7	2	6.7
- General hire	1	3.3	2	6.7
Total	30	100.0	30	100.0

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic classified according to general characteristics, health, and health service, environment, and health state (Continued)

Description	Thailand		People Republic of Lao	
	Number	Percent	Number	Percent
Income / month (Baht)				
- ≤ 9,999.0	18	60.0	25	83.3
- 10,000-19,999	5	16.7	3	10.0
- 20,000-29,999	5	16.7	1	3.3
- 40,000-49,999	1	3.3	0	0
- ≥ 50,000.0	1	3.3	1	3.3
Total	30	100.0	30	100.0
Thai Mean= 1,1298.67 S.D= 1,2807.98 Mod =5,000.00 Min=0 Max=55,000.00				
Lao Mean= 6,383.33 S.D= 9,764.68 Mod =2,000.00 Min=500.00 Max=50,000.00				
Chronic disease				
- No	25	83.3	28	93.3

- Have	5	16.7	2	6.7
Total	30	100.0	30	100.0
Type of disease				
-Diabetes	0	0	1	50.0
-Heart disease	2	40	0	0
- Toxic thyroid	1	20	0	0
- Peptic Ulcer	0	0	1	50.0
- Blood pressure	1	20	0	0
-Allergy	1	20	0	0
Total	5	100.0	2	100.0
The whole health state of self-evaluated				
-The best level	2	6.7	20	66.7
- Good level	14	46.7	7	23.3
-Moderate level	12	40.0	3	10.0
- Poor level	2	6.7	0	0
Total	30	100.0	30	100.0

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic classified according to general characteristics, health, and health service, environment, and health state (Continued)

Description	Thailand		People Republic of Lao	
	Number	Percent	Number	Percent
Yearly check up				
- Never	17	56.7	13	43.3
-Ever 1 time	5	16.7	6	20.0
- Ever 2 times	3	10.0	3	10.0
- Ever 3 times or more than	4	16.7	8	26.7
Total	30	100.0	30	100.0
When sick, they go to receive the service at				
-Hospital	18	60.0	17	56.7
- Public health center or Health station	2	6.7	0	0
- Clinic of modern medicine	3	10.0	7	23.3
-Buy drug by themselves	1	3.3	2	6.7

- Let it recovers	6	20.0	4	13.3
Total	30	100.0	30	100.0
Interest and study the health information				
-Most interest and regularly practice	9	30.0	10	33.3
- Few interest up to the change provided	18	60.0	8	26.7
- Fewer interest	3	10.0	12	40.0
Total	30	100.0	30	100.0
Water for consumption and drink obtain from				
- Rain water	3	10.0	4	13.3
-Treated tap water	22	73.3	10	33.3
- Untreated tap water	2	6.7	11	36.7
- Canal pool, and well water	3	10.0	5	16.7
Total	30	100.0	30	100.0

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic classified according to general characteristics, health, and health service, environment, and health state (Continued)

Description	Thailand		People Republic of Lao	
	Number	Percent	Number	Percent
Toilet				
- No	1	3.3	5	16.7
- Have (lavatory with septic tanks)	29	96.7	25	83.3
Total	30	100.0	30	100.0
Waste Management				
- Natural throw away	2	6.7	2	6.7
- Have	28	93.3	28	93.3
Total	30	100.0	30	100.0
Method- Municipal bin	24	85.7	21	75.0
- Self-managed	4	14.3	7	25.0

Total	28	100.0	28	100.0
Food				
-Buy according their satisfaction from the general sale	8	26.7	23	76.7
- Buy with regarding to advantage to body and food safety	22	73.3	7	23.3
Total	30	100.0	30	100.0
Health state level				
- Rather good having the correct way of life	14	46.7	11	36.7
- Moderate, should change the way of life	13	43.3	18	60.0
- Too low, must control the behavior of living	3	10.0	1	3.3
Total	30	100.0	30	100.0
Total of health state level	Moderate level Mean = 85.83 SD = 10.87		Moderate level Mean = 86.10 SD = 8.80	

Results of data analysis on the comparison the association health state between group of sample, the finding revealed that the health state associated to occupation and education with statistically significant at level of 0.05 and 0.01 (Table 2).

Table 2. Analysis on the Comparison the Association Health State Between Thai and Lao According to General Characteristics

Descriptions	Thai N=30(%)	Lao N=30(%)	Percent (100)	Chi-square
Education level				
- Illiteracy	1(1.7)	4(6.7)	8.3	
-Primary school level or lower	12(20.0)	5(8.3)	28.3	
-Secondary school to high school levels	11(18.3)	20(33.3)	51.7	0.02*
- Diploma degree level	3(5)	1(1.7)	6.7	
- Bachelor degree level	3(5)	0	5	
Occupation				

- No occupation	3(5)	4(6.7)	11.7	
-Agriculture	0	5(8.3)	8.3	
- Merchant	19(31.7)	10(16.7)	48.3	
- Business	5(8.3)	7(11.7)	20.0	0.01**
-Governmental, state enterprise, private officer	2(3.33	2(3.3)	6.7	
- General hire	1(1.7)	2(3.3)	5.0	

**P<0.01, *P< 0.05

Results of data analysis on the comparison the mean scores of way of life in different aspects between Thailand and Republic of Lao, the finding revealed that food consumption and excretion, smoking, alcohol, drug and toxic substance, work, exercise, and recreation, dental health, and traffic, family and social aspects, the total results had no different except the sexual relation had the sexual relation with statistically significant at level of 0.01. But By each item, there were differences with statistically significant at level of 0.01 and 0.05 at presents in table 3.

Table 3. Analysis on the Comparison the Mean Scores of Health State between Thailand and Lao People's Democratic Republic

Descriptions	Thailand		Republic of Lao People		T-Test
	Mean	S.D	Mean	S.D	
Food consumption aspect					
-Have the mean with how many main meals per day	2.6	0.7	3.0	0.2	0.02*
- Meal with the most amount is	1.8	0.8	2.4	0.6	0.01**
- Have a snack, how many times per day	2.5	0.9	1.8	0.9	0.00**
- Have rice group and carbohydrate, how many ladle per day	1.5	0.8	2.0	0.8	0.01**
- Have meat, egg, soybean cake or bean, how many spoon per day	1.5	0.9	2.0	0.6	0.04*
- Have fat food such as coconut milk, chicken skin, leg, pork leg, fat pork, , how many time per week	2.7	2.1	0.8	0.8	0.01**
- Satisfy with body weight at present	1.6	2.5	0.6	0.6	0.00**
Smoking, alcohol, drug and toxic substance aspect					
- Drink coffee/ ice coffee or caffeine drink such as					

Coke or Stimulant drink, how many cups per day.	2.7	2.4	0.7	0.7	0.01**
Work, exercise, and recreation aspect					
- Sleep 6-8 hours, how many night per week	2.7	2.2	0.9	0.9	0.02*
- Work over than 8 hours per day, How many day per week	1.3	1.6	0.8	0.8	0.01**
Family and social aspect					
-Satisfactory feeling for family, neighbor, and community with warm of mind and emotion support	2.3	2.4	0.5	0.5	0.00**
Sexual relation (Whole Behavior) aspect	6.1	0.8	4.4	1.7	0.00**
-Convenient feeling and satisfaction to master base instead of have sexual affair with others	0.3	0.7	0.2	0.6	0.00**
- Have sexual relation with security of safe from pregnancy, how often	2.9	0.3	1.9	1.4	0.00**

**P<0.01, *P< 0.05

Discussion

From the research results, it can be concluded according to each aspect of two courtiers were as follows:

1. The demographic characteristic of two countries, most of them had no chronic disease. For Thailand, the finding illustrated that there are heart disease, hypertension, and allergy. These diseases occurred from the behavior of health and environmental pollution. Lao People's Democratic Republic, the result showed that there were peptic ulcer and diabetes diseases. These diseases were occurred from food behavior consumption because most of them bought food according to their satisfaction and bought from the general food sale. The finding also indicated that people of both countries pay little attention to health information up to the chance provided and most of them went to receive the health service from the hospital. Nevertheless, some of them bought the drug from drug store and let it naturally recovers.

2. Environmental aspect

1) Water for drink and utility, most of them used the treated pap water but some of them still used the natural water so its quality depended on natural environment.

2) Toilet, most of them used the standard toilet but some of them still had no toilet and this will be a cause of disease spreading if it was neglected.

3) Waste management, few of them disposed to natural environment but it also caused of pollution.

3. Way of life, the finding showed that whole health for way of life was at moderate level but in some aspect, it needed to improve individual behavior of lifestyle. The different of the whole lifestyles found that sexual relation aspect for Lao, they were still lack of knowledge and behavior of self-practice was not proper in the following aspects:

1) Food consumption behavior, most of Lao people will have better food consumption behavior in the issue of have three meals, particularly have breakfast. Amount of carbohydrate, meat, egg, soybean cake or bean were appropriate proportion body demand so they had a standard of body weight. But Thai people prefer to eat snack and have high fat food.

2) Tobacco, alcohol, drug, and toxic substance, it was found that Thai people drink coffee/ice coffee or stimulant drink with caffeine less than Lao people.

3) Work aspect, it was found that Lao people worked longer 8 hours per day in a week less than Thai. For sleeping aspect, it was found that Thai sleep 6-8 hours less than Lao.

4) Family and social aspect, the feeling of satisfaction for family, neighbor, and community with warmness and mental and emotional support among Lao people more than Thai.

Recommendations

The features of both countries had the whole health state at the moderate level. It should be changed some behavior of lifestyles in order to have a healthier level as follows:

1. Environmental aspect, the state should support and implement.

1) Check for water quality of natural water that is used by people whether it is proper to use for consumption or not.

2) Toilet, every family should have toilet because it is a source of pollution and source of different disease spreading.

3) Waste management, government should play clearly role for implantation of waste seriously in term of community law utilization with public relation is made on recycling, and utilization. It should not throw waste to the natural environment, particularly the Mekong River.

2. Knowledge aspect, distributing knowledge through the media of radio, television, and printing materials to people in order to let them have more knowledge in the following issues:

1) Food consumption and Excretion;

2) Tobacco, alcohol, and drug consumption, and toxic substance contamination;

3) Dental health;

4) Behavior of car and road;

5) Work, exercise and recreation;

6) Family and society;

7) Sexual relationship.

3. Arrange the movement unit in the health aspect to check health, recommendation is provided to people who can not reach the basic service of government.

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Development of Health Cities Network for the Mekong Region

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Abstract

The objective of this research is to develop a healthy cities network for Mekong Region. The population consisted of all cities in the five countries along the Mekong River Basin. The sample groups included five cities representing each of the five countries, selected by purpose sampling technique through the basis of their commitment to participate and cooperate. The cooperation to establish a healthy cities network will be implemented through both bottom-up and top-down approaches. For the top-down approach, the city authorities needed to participate in participatory training that integrated the Appreciate-Influence-Control technique (AIC), in order to establish the Mekong healthy cities agenda with a shared vision based on the healthy cities concept to meet sustainable development. This would lead to cooperation among the representatives from the five cities, so that they may create policies and plans for implementation to harmoniously join in at the local level. Regarding bottom-up approach, the local authorities in the five cities needed to set action plans relevant to the city authority. The research design employed in this study is thus divided into two levels of approaches: bottom-up and top-down. A network development process will be implemented for both levels with Multi-level Management Linkage (MML) concept, and after the end of the

project, Participatory Performance, Assessment, Monitoring, Evaluation, and Impact (PAMIE) technique will be used for evaluation (Thiengkamol, N., 2004). Nevertheless, before the full research will be implemented the preliminary survey is needed.

Key words: Development/ Healthy Cities Network/ Mekong Region

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Introduction

To meet the sustainable development of five countries along the Mekong River Basin, it needs the cooperation with a shared vision based on the Healthy Cities Concepts (HCC) because its basic concept covers all aspects that leads to the well being of all population in this region. Particularly, at present, the international water likes as the Mekong Basin is going to be an important problem of conflict of interest with the need of use the fresh water for living of people who live at the bank of Mekong River. Moreover, with the transborder of these countries also develop various interesting issues whether sex trade, gender and sexuality, labor migration, natural resource and environment management, culture, ethnicity, human right regarding ethnic, and health, particularly HIV/ADIS.

The HCC is harmonious with the philosophy of sustainable development because its concept regarding to good quality environment that people lives. This includes good quality of air, water and soil, plenty of health food and good housing. In addition, the various facets that influence this concept are quality of life, education, vital culture, good health care for both mental and physical aspects, satisfying employment and occupation, the sharing of wealth, and safety in public places, supportive relationships, equal opportunities, and freedom of expression. In addition, the special needs of the young, and the old or disabled also be emphasized (Belfast Healthy Cities Project, 1998 and WHO).

As far as it has been recognized, at present the mean of network development has been employed for linking in different areas in different levels as individual, groups, and organization such as education in term of learning network development, web page in form of on-line linkage, and career linkage in term of collaboration. But The research

design in this study, the development of Healthy City Network (HCN) for the top-down approach, the city authorities need to participate in participatory training that integrated the Appreciate-Influence-Control technique (AIC) with the brain storming of city authorities in order to establish the Mekong healthy cities agenda and for the bottom up approach will employed the invented techniques of MML and AIC techniques with the integration of SWOT (Strength-Weakness-Opportunity-Threat) analysis to develop a healthy cities network for Mekong Region. The quality and success of the HCN development will be evaluated by PAMIE technique composed of both qualitative and qualitative methods.

Literature Review

At the beginning period of healthy cities project, World Health Organization (WHO) defined health in 1948 as "A statement of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". This wide definition covers to different factors relates the health that includes environment, relationships, level of income, lifestyle, government policy, and employment for instance.

The second phase of WHO European Healthy Cities Projects (HCPs) included the commitments with following principles of the project regarding healthy city policy, community participation, and all stakeholders' cooperation, attaining the healthier environment and health, and primary health care at the community level.

The World Health Organization Healthy Cities movement is stronger and more relevant than ever. There is now plenty recognition of the importance of the local dimensions and the key role of local governments and the civic society in health and sustainable development. Healthy City (HC) had 15 years experience of innovative action developed through times of major social and political changes regionally and globally. The conference marked the successful conclusion of the third phase (1998-2002) of the WHO European Healthy Cities Network (HCN) with the main goal of projects by acting to improve the health of their residents and the launching of Phase IV (2003-2007). The

conference offered a meeting point and platform to cities, networks, agencies and institutions that are concerned with health, sustainability, equity, urban development and community empowerment (WHO, 1998).

The HCP can consider in term of the principles of sustainable development that has implemented in both developing and industrialized countries. The appropriate techniques will be introduced as tools that lead to meet the goal of wellbeing both mental and physical health of global citizen. It requires through both bottom-up and top-down approaches. For the top-down approach, the city authorities need to participate in participatory training that integrated the Appreciate-Influence-Control technique (AIC) (World Bank, 2002), integrated with Multi-level Management Linkage (MML) with the integration of SWOT (Strength-Weakness-Opportunity-Threat) analysis and project operation methods of Who, Whom, What, When, Where, Why, and How (6W1H) (Thiengkamol, N., 2004; World Bank, 2002; Langly, 1998; Weiss, 1993 and Sproull, 1988). to develop a healthy cities network for Mekong Region. (Thiengkamol, N., 2004). In order to establish the Mekong healthy cities agenda with a shared vision based on the HCC to meet sustainable development. This would lead to cooperation among the representatives from the five cities, so that they must create policies and plans for implementation to harmoniously join in at the local level. Regarding bottom-up approach, the local authorities in the five cities need to set the shared vision action plans relevant to the city authority. Nevertheless, at each local level might have some different contexts so it needs to implement some as priority issues like as the previous project of Belfast Healthy Cities Project (Belfast Healthy Cities Project. 1996). Nevertheless, it might be the same the previous or not it depends on the context of the cities that project will be implemented.

Healthy City Project in the aspect of Urban health is an increasingly interconnected and challenging field of action for the European Region of the World Health Organization (WHO). Plenty of studies and reports emphasize the growing health challenges of cities such as social exclusion, pollution, poverty, violence, substandard

housing, the unmet needs of elderly and young people, homeless people and migrants, unhealthy spatial planning, the lack of participatory practices and the need to seriously address inequality and sustainable development. Over 1000 cities and towns from more than 30 countries of the WHO have he Healthy Cities project in the European Region has shown the value of a holistic approach to such problems. It is an effective and popular mechanism for promoting policies and program based on health for all at the local level through a process that involves explicit political commitment, institutional changes and intersectoral partnerships, innovative actions addressing all aspects of health and living conditions and extensive networking between cities across Europe (WHO, 2005).

These countries are linked through national, regional, metropolitan and thematic healthy cities networks, as well as the WHO Healthy Cities network for more advanced healthy cities. Cities participating in these networks have developed and implemented a wide range of program and products including city health profiles and city health plans and strategies based on intersectoral cooperation, community development initiatives and program that address the needs of vulnerable groups, lifestyles, environmental health and Agenda 21 that is core concept of sustainable development (WHO, 2003 and WHO, 2005).

The WHO Healthy Cities network represents a key mechanism for promoting commitment and innovation and is a source of valuable expertise, legitimacy and continuous learning. National networks and a host of thematic networks at the international and national levels have developed into a dynamic web of innovation and cooperation that cuts across all conventional political, professional, territorial and sectoral boundaries (WHO, 2005).

Therefore, coverage of this study will be concentrated on the different aspects of lifestyles, wellbeing, environmental management, cultural transferring, and health state, including HIV/AIDS situations. Firstly preliminary survey was done at the lower area of Mekong region by using Thailand and Loa as pilot study to search basic information of their people knowledge and understanding about the Healthy Cities Concepts (HCCs). In

addition, the culture in the aspect of cultural perception and belief on different issues whether its traditional performance, or belief on religion, spirit, mind, ritual, ghost, environmental and natural resources, and supernatural events. Moreover, in this pilot study the other important aspects of lifestyles, health state including the aspect of HIV/AIDS, and environmental management. Afterward, the HCN development will be operated with the participatory training will be implemented both will be operated through both bottom-up and top-down approaches.

During the training process, participants of both levels will be assessed with the Tree Dimensional Evaluation (TDE) and Four Dimensional Evaluation (FDE) or Round Dimensional Evaluation (RDE). TDE included evaluation: self-evaluation, group-evaluation, and trainer-evaluation. FDE or RDE included self-evaluation, group-evaluation, trainer-evaluation, and audience-evaluation (Thiengkamol, N., 2004). Participatory Performance, Assessment, Monitoring, Evaluation, and Impact (PAMEI), is used as systematic evaluation in order to assess, monitor, and evaluate the participants performance and impacts, and the quality and success of the HCN development will be evaluated both quantitative approach with questionnaire and observation forms, and qualitative in term of Participatory Action Research (PAR).

Ultimately, The HCN for Mekong Region will be established with the collaborations of Cambodia, China's Yunnan Province, Loa, Thailand, and Vietnam to implements of HCPs as based to reach the sustainable development according to the set Mekong Healthy Cities Agenda (MHCA) as guideline for policy formulation and planning for action plan with short term and long term projects.

The complicated elements and dynamic activities in every city, are features like as the building blocks and functions in the living organism because both of them are able to retain as living city or living creature have to contain various compositions and function as well. The city contains various fundamental elements both living and non-living things, and dynamic activities include politics, economics, business, societies, education, security, culture, way of living, and career. Nevertheless, the city can be considered as

living creature in term of health. The city health, therefore, regards plenty of factors that represents its outcome of healthy state in terms of development with the good quality of environment and enrich natural resources. Human wellbeing both physical and mental health, no unemployment, peace, security, and equality of right to reach the social affair in different facets are included (Mega, V., 1996; WHO, 1998; Rees, W., & Lawrence, R., 1996; and World Commission on Environment and Development, 1987).

Considering in term of healthy cities concept, WHO has established the Healthy Cities projects to explore the opportunities and mechanisms for developing the collaborative action in cities to achieve health for all Health is defined as being outcome of all factors that affect human being (WHO, 1998; and European Sustainable Cities & Towns Campaign' Healthy Cities Network, WHO Regional Office for Europe, and Healthy Cities Network, 1997).

Moreover, Agenda 21 and health for all programs have various common principles and complementary processes. Even though Agenda 21 inspects health as the outcome of environmental, economic, and social factors that also affect sustainable development (European Sustainable Cities & Towns Campaign' Healthy Cities Network, WHO Regional Office for Europe, and Healthy Cities Network., 1997; and Pearce, D., 1995).

From the beginning implementation of Healthy City Project (HCP) in 1948 until present, it is obviously seen that if the project should be implemented in both level approaches, particularly, at present the world is facing to different dimensional problems that need harmonizing cooperation among different countries to reach the HCC to meet the global sustainable development. For the regional level likes as Mekong Region, it needs a cooperation among countries locate on Mekong River to link as strongly network to assist each other to attain the regional sustainable development by operating with HCC.

Since Network development is an important role to link the different stakeholders to participate and do brain storming to explore the shared vision for implementation to reach the goal of sustainable development in various facets whether for business,

education, economic, politic, administrative and earning approach (ASEAN Business Council, 1992; Sripoona, S., 2001; and Saengngern, S., 2002; Photchanachai, K., 1993; Office of National Committee Village and Urban Community Fund, Office of Prime Minister., 2003 and Thiengkamol, T., 2004).

Occurrence or establishment of network, there are different mechanism, but for Development of Health Cities Network for Mekong Region in this research, it will be implemented by applying the model of MML concept and evaluating with PAMIE techniques (Thiengkamol, T., 2004). Regarding the MML concept, there are at least three levels of continuous participatory training based on multi level management linkage. The first level of training (or District level) will be initiated by the research team to provide the facilities and management of the first level training, then the participants of this level will perform as steering committee to operate in the second level (Subdistrict level) training with the aid of researcher team. For the third level (community level) training, the second level participants will perform as steering committee to operate in the third level training with aid of steering committee formed by first level participants, including research team's advice. Then, the three levels participants would be join to operate the establishing network to collaborate in their own level or other levels with the connecting with the top authorities in term of city or town level. Particularly, for the Mekong Region five city authorities who participates in participatory training with the formulation of the Mekong healthy cities agenda in order to reach the sustainable development. During and after the projects implementation, PAMIE will be employed to assess and monitor based on the qualitative and quantitative approaches.

Methodology

The research design is implemented in steps by step as follows:

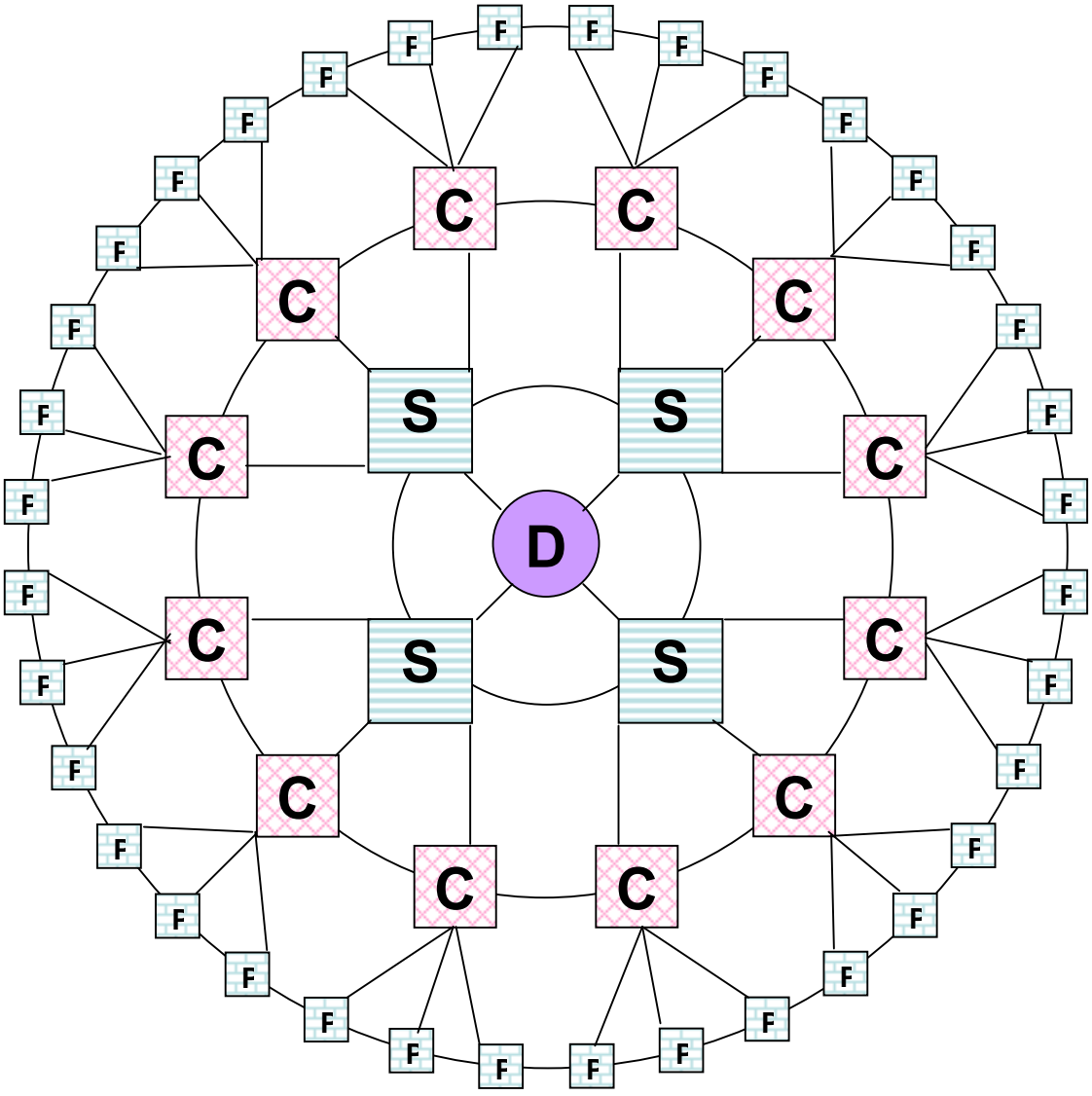
1) The preliminary survey is done in order to search the basic information of the population demographic characteristics, healthy city knowledge and understanding, lifestyles, environment situation health state, particularly HIV/ADIS status.

2) Tools, the questionnaires for evaluation the knowledge achievement and understanding on the concept of health city network development of participants, and the forms of Three Dimensional Evaluation, and Round Dimensional Evaluation are constructed.
3) The questionnaires to determine the reliability of each question and the whole paper was done by determining the alpha coefficient (α-coefficient) (Sproull, 1988).
4) For the top down approach, the five cities of top authorities is arranged for the participatory training for 3 days in order to do the brain storming to obtain Mekong healthy cities agenda with a shared vision based on the healthy cities concept to meet sustainable development. Moreover they will bring the Mekong healthy cities agenda to policy maker to formulate the policy and action plans for both short and long terms projects.
5) For the bottom up, local authorities participate in the participatory training for 3 days in order to do the brain storming to obtain Mekong healthy cities agenda with a shared vision based on the healthy cities concept to meet sustainable development. They will also propose the Mekong healthy cities agenda to policy maker to formulate the policy and action plans for both short and long terms projects.
6) Construction of handbook for the training: it contains the healthy city concept, network development, the operating with the concept of MML, and the sustainable development concept (Markasiranonth, 1999; CEDPA, 1999 and Thiengkamol, N., 2004).
7) The district leaders will be selected with purposive sampling from the whole district level to be participants in the training course arrangement with MML concepts. They will be recruited according to the setting criteria (willingness, time, devote, and public mind).
8) The first level training course for 5 days, and the 30 participants were One Group Pretest-Posttest Design is employed for determination the learning knowledge achievement and understanding of the healthy city concept, network development, the operating with the concept of MML, and the sustainable development concept. The systematic operation of three level training courses were prepared for training the participants to be able to perform as trainer, facilitator and educator for HCP

implementation and network development via invented Multi-level Management Linkage (MML) with 'Training of Trainer' (TOT) process integrated with Appreciate-Influence-Control (AIC). Moreover, they would be able to develop an action plan and projects for HCP according to the shared vision obtained through brain storming at each training level based on the Mekong healthy cities agenda with a shared vision based on the healthy cities concept. The brain storming included SWOT (Strength-Weakness-Opportunity-Threat) analysis based on project operation methods of Who, Whom, What, When, Where, Why, and How (6W1H) (Langly, 1998; Weiss, 1993; and Sproull, 1988).

9) The Three Dimensional Evaluation and Four or Round Dimensional Evaluation is used to qualify the participants to be facilitator and trainer.
10) The first level participant held a meeting to select the steering committee for operation the second level training course, simultaneously; the first level participants would practice giving knowledge for their district people under the supervision of the researcher and trainers.
11) The second level of the training course is arranged for 5 days, and the 30 participants from the subdistrict leaders are recruited according to the setting criteria. The participants of the first level performed as the trainers and facilitators for the second level participants under the assistant and supervision of the researcher and trainers.
12) The Three Dimensional Evaluation and Round Dimensional Evaluation were used to qualify the participants to be facilitator and trainer performances.
13) The second level participant held meeting to select the steering committee for operation of the second level training course, simultaneously, the second level participants practice to give knowledge to their subdistrict people under the supervision of the researcher and trainers, and the assistant of the first level participants.
14) The third level was implemented according to process mentioned above with the participants who are the community leaders.
15) PAMEI technique is employed for performance, assessment, monitoring, evaluating for training participation and facilitator and trainer performance of the participants, including the cooperation of operation and management of training course as steering

committee. The research design of the Development of Healthy Cities Network for Mekong Region shows in figure 1.



NB: D=District, S=Subdistrict, C=Community, P=People

Figure 1 Development of Healthy Cities Network for Mekong Region with MML

Research Results

The results of survey research with the questionnaires contained of different aspect of general knowledge and perception on healthy city concept, culture, environmental management, lifestyles, and health state, including HIV/AIDS, illustrated as follows:

For The aspect of HCC, it indicated that at the country level of lower region of Mekong basin, regarding on Lao People's Democratic Republic and Thailand, the finding illustrated that the nation associated to healthy city concept statistically significant at level of .05 with regarding the issues of healthy cities as follows:

1) HC must have the management in different aspects such as environment, health, and security of life and properties.
2) HC must be clean, and safety without any pollutions.
3) HC must regard to the people with qualified education, healthy body and mind with the public awareness behavior.
4) HCP management should be implemented with the cooperation of the city authority and their citizen.
5) HC Healthy city concept includes art, culture, and local wisdom.
6) HC also regards to the public parks and Health Park providing for citizen.
7) HCC embraces of information providing about healthy city project.
8) HCC includes to the individual family healthiness.
9) HCC includes the people do not dispose the solid waste and waste water to river, canal, and water sources in term of environmental management.
10) HC must free for drug addict problem.
11) HCC, the government needs to provide knowledge and understanding to the citizen in order to meet the shared vision of sustainable development.

The finding in the aspects of lifestyles, cultural belief and perception, environmental management and health state including the HIV/AIDS situation are as follows:

1) Lifestyle aspect at the country level of lower region of Mekong basin, regarding on Loa and Thailand, the finding illustrated that the nations did not associate to lifestyles at level of .05 (Koktatong, K., 2005).
2) Health state Thailand, the finding illustrated that health state of two nations were in the moderate level, but when considering on the individual of both countries, the result illustrated that there is different health state. Moreover, when the comparison of daily lifestyles between two countries, there were no differences with statistically different at level of .05. The food consumption behavior was exception (Koktatong, K., 2005). Including sexual relation, this was relevant to the result of the association of nation and HIV/AIDS situation (Charoensuk, D., 2005).
3) HIV/AIDS situation of the country level of lower region of Mekong basin, regarding on Lao People's Democratic Republic and Thailand, the finding illustrated that both of the nation associated to HIV/AIDS situation at level of .05 (Charoensuk, D., 2005).
4) Environmental management aspect at the country level of lower region of Mekong basin, regarding on Loa and Thailand, the finding illustrated that the nations did not associate to lifestyles at level of .05, except in the facets of aid for conservation of environment and natural resources inside the community, awareness of forest resources use, the international agreement of aquatic animal fishing about the conservation considering, waste disposal, and environment and natural conservation for Mekong river (Suphama, S., 2005).
5) Cultural perception and belief aspect, the finding indicated at the country level of lower region of Mekong basin, regarding on Loa and Thailand, the finding illustrated that the nation associated to cultural perception and belief with statistically significant at level of .05 (Krauewan, K., 2005).

When the comparison in different aspects was done with the twin cities Mukdahan Province and Kunthaburi City. Comparison two cities in term of health status and culture belief had no different with statistically significant at 0.05 level, but perception on healthy

city concept, and environmental management had different with statistically significant at 0.05 level.

From the preliminary research, it can be concluded that there are still various different aspects among countries locating at Mekong River banks. Therefore, before the health city network will be develop, it needs to prepare for the survey research for fives cities that will be used at representatives in order to plan and manage for the process of effective implementation process and effectiveness out come and impact.

Discussion

From the research survey, for the healthy city aspect, the association between demographic characteristics of the sample group and healthy city concept, the results were discovered that the country or race, and education level associated to healthy city concept with statistically significant at level of .05. Especially, in the aspects of the management in different aspects such as environment, healths, and security of life and properties, qualified education, free for drug addict problem, healthy body and mind with the public awareness behavior, are included. Moreover, HCC also regards to art, culture, and local wisdom. In addition, HCC includes the people do not dispose the solid waste and waste water to river, canal, and water sources in term of environmental management, and the government needs to provide knowledge and understanding to the citizen in order to meet the shared vision of sustainable development.

The finding indicated that most of the lower region, particularly, Laotian and Thai people who live in the Mukdahan Province and Kunthaburi City. Comparison two cities in term of health status and culture belief had no different with statistically significant at 0.05 level except the food consumption behavior. But perception on healthy city concept, and environmental management had different with statistically significant at 0.05 level. This indicated that it needs to provide certain knowledge and environmental management for both cities people by giving more information through different channels such as television, radio and village. Moreover, the healthy city project that will plan to implement, should arrange the facet of knowledge and understanding for local level by the leaders of different levels as district, subdistrict, and community leader to give these content during the process of health city network development for Mekong Region.

The significance of healthy cities network is concentrated when the plenty of countries have faced with the environment problems, shortage of natural resources to nurture the human being. This situation is a menace for the poor people with physical mental health statuses. Particularly, for the developing countries and less developed countries are threaten by the globalization and the world economic competitions.

Therefore, the poor become poorer due to the lack of knowledge and know how of technologies due to their lower opportunities and low competencies with the low level education. Most of the world population about 80 percents are sill in the remote region to reach the facilities built by the high technology, especially, the information technology progression. Nevertheless, there is various international organizations tries to assist to alleviate these urgent troubles.

The network development is in the attention of plenty of field whether business, education, politics, earning and so on. In this study the network development process is employed the invented Multi-level Management Linkage (MML) with 'Training of Trainer' (TOT) process integrated with Appreciate-Influence-Control (AIC). Moreover, they would be able to develop an action plan and projects for HCP according to the shared vision obtained through brain storming at each training level based on the Mekong healthy cities agenda with a shared vision regarding the healthy cities concept. The brain storming included SWOT (Strength-Weakness-Opportunity-Threat) analysis with integrated the participatory training approach as a means to educate people health cities concept in different aspects to diverse target groups in order to accomplish sustainable development as the highest ultimate goal of development. Moreover, it associated challenges, developed the necessary skills and expertise to address the challenges and foster attitudes, motivations and commitment to make informed decisions and take responsible action. Additionally, it enhanced critical thinking, problem-solving and effective decision-making skills. Therefore, the demand for health cities knowledge in order to seek the effective model continued to grow in the response of international agencies, including at the regional, country and local level are required.

Therefore, further studies should emphasize on the development of health cities network model for attaining the wellbeing of citizen for five countries locate on the Mekong River. If most of the leaders different sectors, who will attend in all three levels of training, have high capabilities, responsibility and intentions to be trainers for their district, subdistrict and community and others with sincere devotion to establish a health cities network for their cites according to the research designation.

Based on the preliminary study was done in different aspect of general knowledge and perception on healthy city concept, lifestyles, culture, environmental management, and health status, especially, HIV/AIDS. It indicated that the Mekong basin needs to develop the healthy cities projects according to the proposal by implementing based on the mentions concepts and techniques mentioned above.

Recommendations for further research: the development of health cities network should be implemented among countries on the Mekong Region in order to attain the wellbeing of people both physical and mental health with the equality based on the human right and friendly sound relationship. Moreover this health cities network development model can be adapted for implementation with other types of networks for the cooperation in other aspects among the countries that have the transborder in the other parts of world in order to lead the real sustainable development.

Details of PAMEI technique

Participatory Performance (P) is a mean to observe and examine the participant performance in the training course of MML techniques in two phases: firstly during the period of participation in the training course and secondly as trainer performing after training was received, by expressing their capability as a facilitator, educator and trainer individually or collectively with the network or other groups in the community and other societies.

Participatory Assessment (A) is a method for determining, from the participant point of view: what activities are needed and can be supported; they have identified the right problem and right solutions via using the application of Appreciate-Influence-Control Process (AIC) with integration of the SWOT analysis technique for seek a shared vision to set plan and project to implement to accomplish the objectives of healthy city concept.

Participatory Monitoring (M) is a systematic recording and periodic analysis of information that has been chosen and recorded by participants with the help of researcher team, and with the main purpose being to provide information during the life of the project, so that adjustments and/or modifications can be made if necessary.

Participatory Evaluation (E) is an opportunity for both researcher team and participants to stop and reflect on the past in order to make decisions about the future. Participants are encouraged and supported by researcher team to take responsibility and control of planning what is to be evaluated, how the evaluation will be done, carrying out the evaluation, and analyzing information and presenting evaluation results, since the participants already intuitively and informally evaluate, in light of their own individual and/or group, the objectives. The evaluation was done by employing the invented Three Dimensional Evaluation (TDE) for the training course achievement and invented Four Dimensional Evaluation (FDE) or Round Dimensional Evaluation (RDE) techniques for trainer performances of participants.

Participatory Impact (I) is an activity to be practiced by participants, in order to perform as trainers or for participation in training courses to provide knowledge for different groups or institutes in the communities on the issue of healthy cities network development process, including getting the district, subdistrict, and community people to participate in activities such as meetings held in the district, subdistrict, and community for giving knowledge about healthy cities concept and taking part in a project healthy cities implementation.

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Development of Healthy Cities Network for the Prevention of HIV/AIDS in the Mekong Region

By

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Abstract:

The objective of this research is to develop a healthy cities network for the prevention of HIV/AIDS in the Mekong Region. The population consisted of GO, NGO who take responsibilities in the prevention of HIV/AIDS and impacts groups in all cities of the five countries along the Mekong River Basin. The sample groups are representative of each of the nodes (GO, NGO, AIDS impacts group) from five cities that representing each of the five countries, selected by purpose sampling technique through the basis of their commitment to participate and cooperate.

The cooperation to establish a healthy cities network for HIV/AIDS prevention will be implemented through both bottom-up and top-down approaches. For the top-down approaches, the city authorities need to employ participatory action in order to establish the Mekong healthy cities agenda with a shared vision based on the healthy cities concept to prevent HIV/AIDS. This would lead to cooperation among the representatives from the five cities, so that they may create policies and plans for implementation to harmoniously join in at the local level. Regarding bottom-up approaches, impact groups from HIV/AIDS will join with the authorities from GO, NGO in the five cities in order to set action plans relevant to the city authority.

The research design employed in this study is thus divided into two levels of approaches: bottom-up and top-down. A network development process will be implemented for both levels with Multi-level Management Linkage (MML) concept, and after the end of the project, Participatory Performance, Assessment, Monitoring, Evaluation, and Impact (PAMIE) technique will be used for evaluation (Thiengkamol, N., 2004).

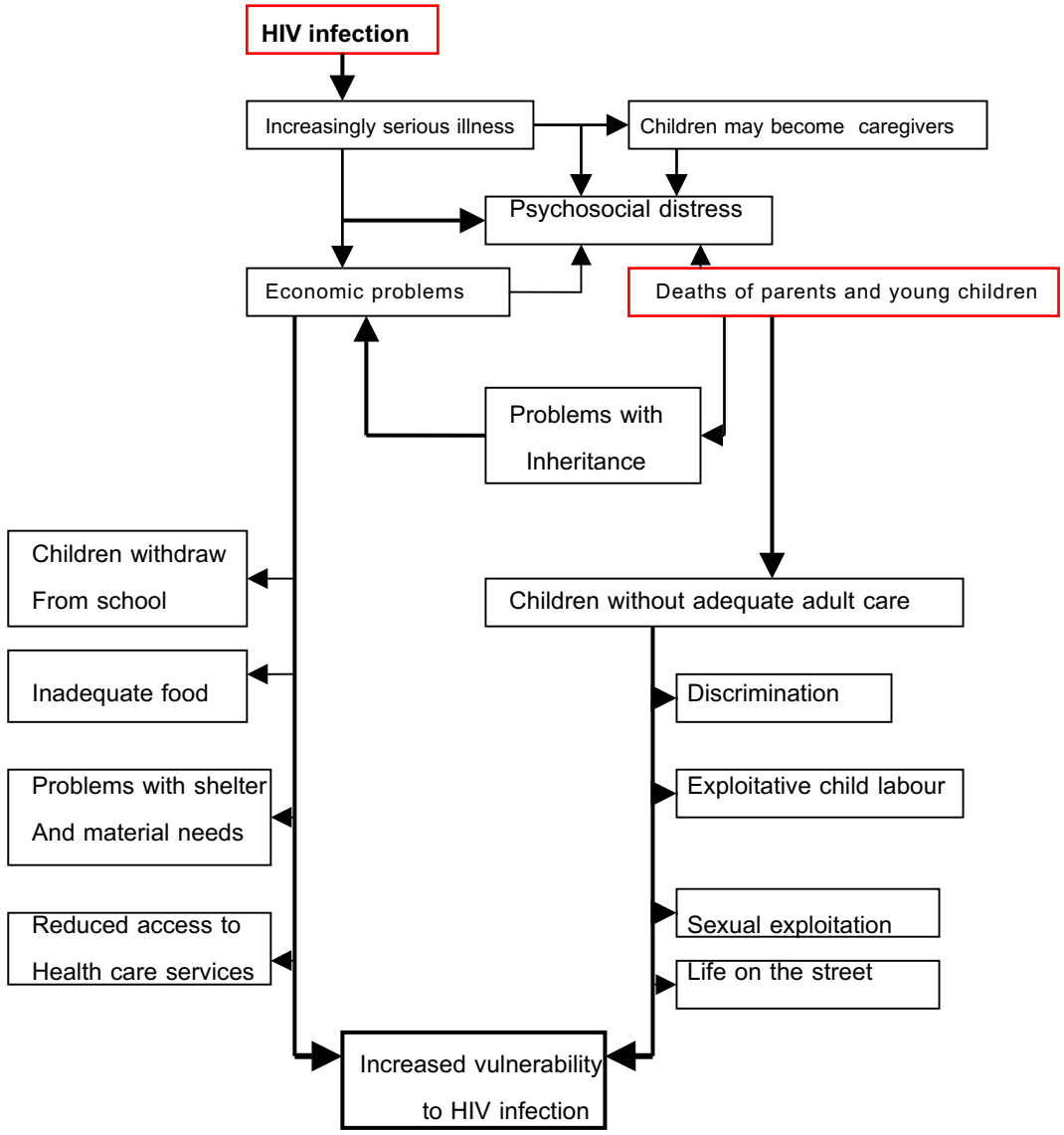
Introduction

The global AIDS pandemic is still in its prime stage and having enormous impacts in Africa and Asia (USAID, 2004). Due to the large population in Asia and the rapid increase in international migration, the number of people in many of the largest Asian nations with HIV/AIDS threatens to surpass the numbers in some of the most severely affected African countries. Even a small increase in the prevalence of AIDS in these countries would lead to a massive increase in HIV/AIDS infection among the population and the impacts would be broadly felt in various sectors of society (http://usgovinfo.about.com, 2004).

The HIV/AIDS epidemic in the Mekong Sub-region is severe: Thailand (740,000), Cambodia (210,000), Myanmar (510,000), Viet Nam (99,000) (Wiwat Rojanapithayakorn WHO, 2000). The region lacks adequate health services and there are high rates of cross border migration. Nowadays the culture of 'free sex' has changed the life style of some people who have no true knowledge about HIV/AIDS. Economics problems, sex trade, and drug-use are all factors that have all contributed to an increase in HIV/AIDS. In particular, poverty, low levels of education and illiteracy forces people to migrate in search for better paying jobs, and there are few opportunities or choices available to them. Some works, such as illegal business, sex trade and trafficking, drug trade makes them vulnerable to health problems and violence. These are reasons why HIV/AIDS has increased in this part of the world. HIV/AIDS affects not only infected people but also their families, communities and has negative impacts on development and the growth of a country. The seriousness of the outcomes of HIVS/AIDS is summarised in figure 1.

Strategies for the prevention of HIV/AIDS have to involve various dimensions, including education, economics, health care systems, law, and society and culture. This means we have to build up networks from each of the nodes (dimensions) listed above in a participatory manner to produce policies for the prevention of HIV/AIDS. Developing a healthy cities network must include both top-down and bottom-up approaches.

Figure 1. Problems among people and family affected by HIV/AIDS



Source: Williamson, J. (2004) A family for life (draft), USAID and the Synergy Project, Washington.

In terms of bottom-up approaches, the researcher has to build up a network by facilitating the interaction between AIDS impact groups, NGOs and GOs in order to find common grounds for action which raise key policy issues that need addressing by authorities. This would also enable the development of a sustainable long-term plan. The main objective of a healthy cities network is to build a shared vision, promote

activities to improve health care and the well-being for people living and working in cities, improve the conditions which mitigate AIDS infections and influence our health, promote healthy lifestyles, improve treatment of illnesses, and reduce the inequalities in access to health care. Approaches to fighting and preventing HIV/AIDS have to be holistic and participatory network strategies must be employed.

Objective of the study

To develop a healthy cities network for the prevention of HIV/AIDS in the Mekong region.

Specific objectives of the research are to:

1). Examine, analyse and assess the needs and health problems of people in the Mekong region by creating a participatory action network in each city of the Mekong region.

2). To develop a one stop service for the prevention of HIV/AIDS by developing a healthy cities network in each city of the Mekong region.

Methodology

The development of a healthy cities network for the prevention of HIV/AIDS in the Mekong region will use participatory action research methods. The cities network are composed of nodes that represent various dimensions such as education, economics, health care systems, laws, social and cultural factors, and AIDS impact groups. The healthy cities network will participate to produce holistic action in HIV/AIDS prevention, problem solving, and one stop service organization for people affected by AIDS using top-down and bottom-up approaches.

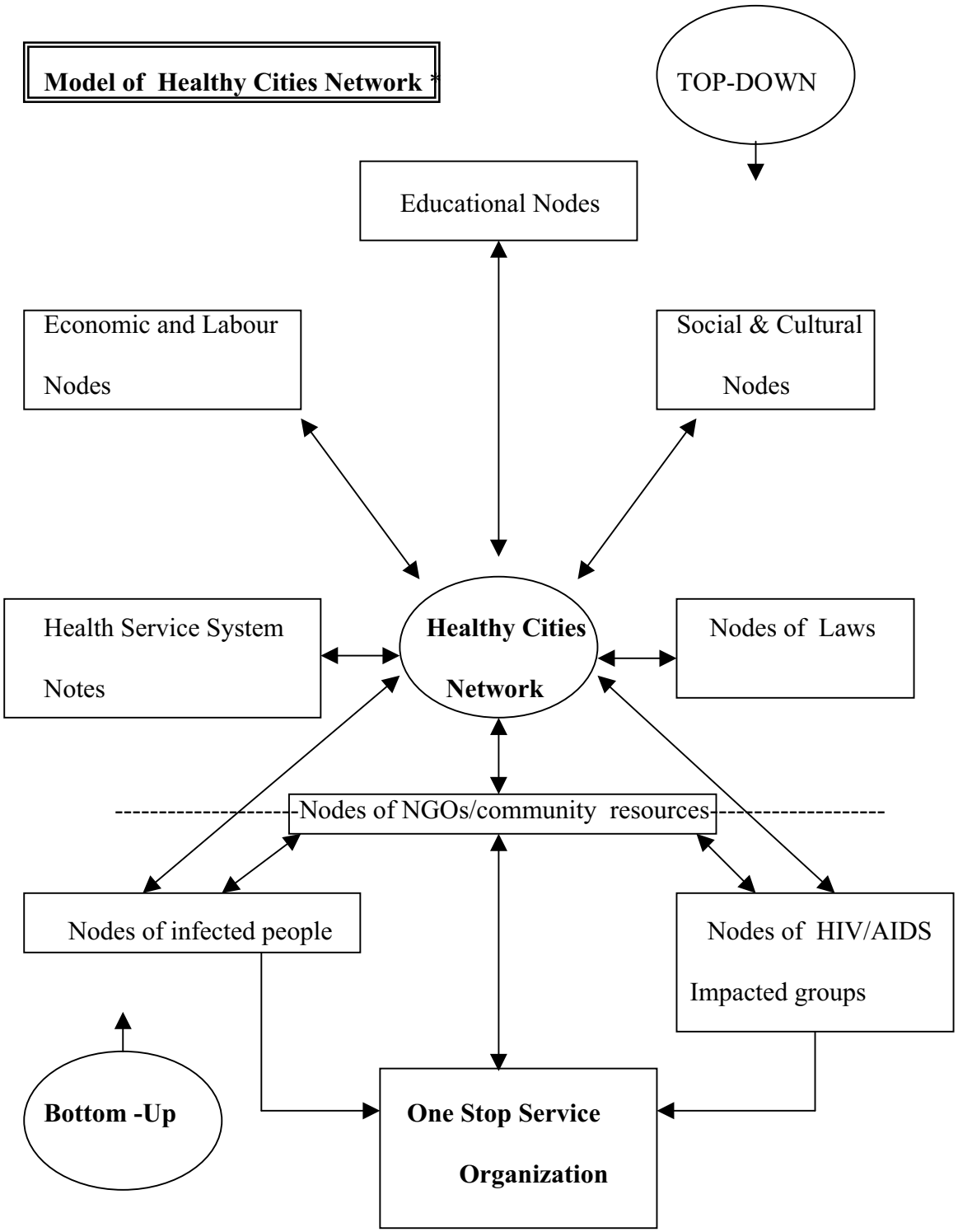
Developing a healthy cities network

- Set up a customer focused working group of volunteers with representatives from each node (dimension).

- The working group will participate in determining the details of the action required and one year targets that will measure progress.
- Representatives in the working group will make sure that they liaise with the relevant network partnerships.
- The core of the healthy cities network will function as a one stop service unit for HIV/AIDS prevention at every level. Both top down and bottom up approaches will be used.
- The financial support will come from government budgets and some from NGO and community resources.

The framework for a healthy cities network is a shared basis for developing collaborative action by all groups concerned for the safety and well-being of vulnerable people. Its implementation will require a broad partnership among many government sectors, donors, and civil society organizations, individual groups and organizations that apply its guidance to their programs in support of vulnerable people. Figure 2 shows a model for a healthy cities network.

Figure 2. Model for a Health Cities Network
Developed by Dusadee (Ratanalangkarn) Charoensuk, 24/05/2005



Network Development

Networks are only the skeletons of complexity, the highways for the various processes that make the world run. To describe society we must dress the links of the social network with actual dynamical interactions between people. Communities are essential components of human social networks. AIDS activities could use community knowledge and resources in social networking group systems to prevent, help and mobilize those who care passionately about the disease, molding them into an effective lobbying and action group. (Albert-Laszlo Barabasi, 2002:170, 223-225). Therefore, this participatory action research will create a healthy cities network and activities will develop into a management system to deal with HIV/AIDS prevention. These activities will help to empower people and provide psychosocial support, build capacity and a network for vulnerable people to be a self-help group. The healthy cities network will thus channel necessary resources to affected groups.

A healthy cities network is a bunch people and their duties and relations. A network contains nodes and lines, where each node represents a dimension such as health division, welfare, education, laws, society and culture, impacted groups, NGOs and communities, etc., and a line is a duty and social relation.

People maintain social networks through practice, discussion, and sharing and exchanging ideas, information, knowledge and resources (Sadao Kudo, 2002:16). Participatory action is the main method for building up a healthy cities network for HIV/AIDS prevention. This framework considers peoples who volunteer to work to combat HIV/AIDS .We also consider volunteers from families and communities to be the foundation of an effective scaled-up response, and includes children and young people as key partners. The Framework provides a shared basis for developing collaborative action by all groups concerned with HIV/AIS prevention the safety and well being of HIV/AIDS patients.

Its implementation will require a broad partnership among researcher teams, local GOs and NGOs. Activities should be based on literature reviews, experiential learning from facilitator teams, and local GOs and NGOs will develop group networks from group interactions. The author's pilot participatory action research study on "Needs, Self-esteem and Health Impact Assessment" in Khon Kaen (2003),

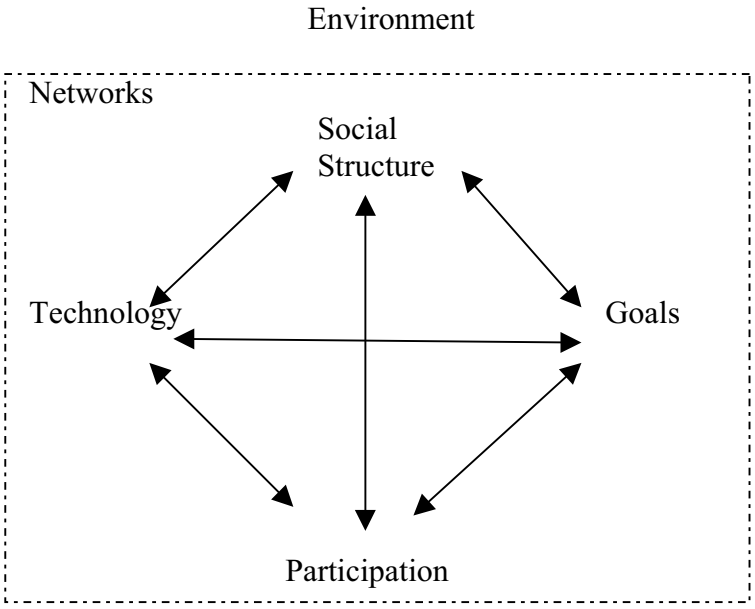
it was found that, first of all, children have to trust facilitator teams because of the AIDS stigma. This led to a reassessment of the project design to include participatory activities that are based on literature reviews and experiential learning reflections from facilitator teams which support psychosocial problems with a focus on the empowerment of sample groups, - people whose lives are affected by HIV/AIDS. This was then applied to the action research project supported by the Rajchaprachasamasai Foundation.

This practice should be done with infected and impacted groups in order to assess their needs and problems. However, as mentioned previously, it is necessary to gain their trust before the network can be developed to include other management and activities.

The healthy cities network will employ a holistic, multilevel approach toward HIV/AIDS prevention and alleviating negative impacts. As Dr. Pravej Wasi stated, "the network will start with a group of people [who] band together to fight a common cause to solve a problem of survival. It is a co-dependent relationship, and when people get together into a community, learning to solve the problems happens" (Wasi, P., 1993b:29).

Elements of the Network

Figure 3. Network Elements



Model adapted from Leavitt (1965, in. Richard Scott, 1992: 16-21)

Social Structure

Social structure refers to the organizations (local GOs, NGOs), communities, concern with AIDS orphans in the aspects of the relationships existing among participants in a social network.

Technology

Technology refers to the information and communications system among networks.

Participation

All social groups in the network need to actively participate for the net work goal to be realized. For this study, the network goal means "the quality of life of AIDS orphans".

Goals

The concept of network goals is important but it is also the most contested. Goals are tentatively defined as conceptions of desired end-conditions that participants attempt to effect through their performance of task activities.

Purpose of Network:

1. Create a platform for information, resource and material sharing among network partners for thematic psychosocial support, evaluation, revision and development of materials, etc.
2. Jointly develop resource materials on PSS (psychosocial support). Some network partners have specific strengths and experiences that can be strategically combined to enhance community responses in the region.
3. Provide technical PSS program support in the region by building a regional pool of grassroots based program consultants. This will enhance program capacity for participating organizations and supports new initiatives with accelerated learning opportunities and support.
4. Facilitate targeted program to program learning exchanges. Such learning exchanges are the most cost-effective way to increase program responses in the region.

5. Develop a regional training program for PSS for qualified staff to train others/monitor/evaluate and support other programs in their locations.
6. Ensure quality of PSS providers. There is need to establish minimal standards of psychological support services.
7. Influence existing programs in the region to scale up through capacity building.

Ekamol Onsri (2001:24-26) studied factors that make network successful in middle and northern parts of Thailand. Groups examined included an urban environmental network in the slum areas of Bangkok and a highland women's network. Some of the factors that led to 'network success' are:

- Networks group members share a similar way of life and problems.
- Network group members share a common view about the end goal/ purpose of the network.
- Good leaders to coordinate, communicate and link all the nodes and during network processes that allows all parts to work together tow achieve common goals.
- Network members are devoted and enthusiastic and share a good relationship between members of network.
- Political structures and policies support their activities.
- They share resources, work in a democratic way, are open-minded, and have good decision-making and management structures in place.
- Networks have good will and are accepted by outsiders and the broader community, both horizontally and vertically.

Network need to be representative, they need to communicate, exchange resources, bring about help, share knowledge, solve problems, empower people inside the network and also form links between the network and the broader community. Effective networks help and empower *all* members of network. The above factors can be used as an index for measuring the success of network. Identifying best practices and disseminating lessons learned will contribute to the program's improvement and the expansion of responses that work.

Network Types and Networking Benefits

There are many types of networks and some people have tried to classify them by their membership, their geographical scope, their main activities, their objectives and their organizational structure. All such classifications have some merit, but the diversity of networks is such that no system of classification is entirely satisfactory. Illustrations of some of the network types are given in the diagrams below (Paul Starkey, 1997:18-19).

Diagram I :

The organizations or individuals cooperate in a highly centralized network or institutional outreach programme. All of the above involve reciprocal relationships with the secretariat, but they do not network with the others.

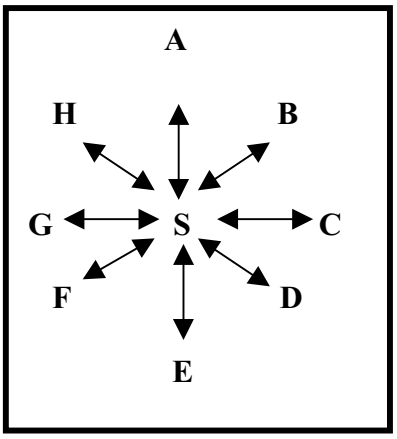


Diagram II:

Network model with secretariat.
The network members interact with each other (not all possible lines are shown) and with a central secretariat that facilitates linkages between members.

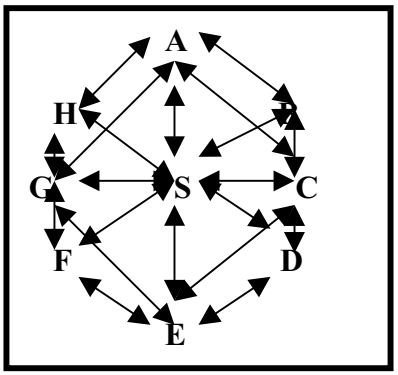
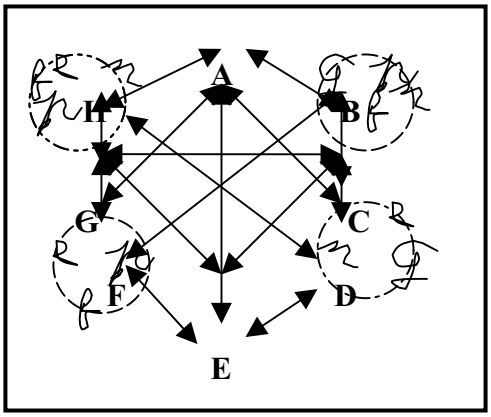


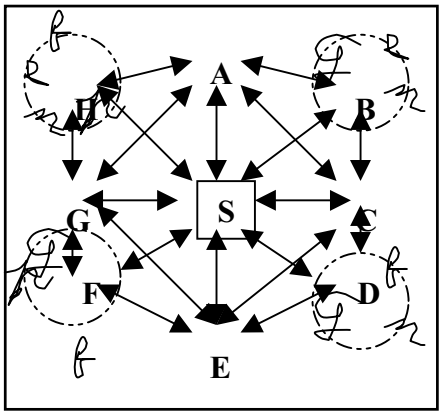
Diagram III:

Decentralized network model.
Active national networks interact with each other and with resource organizations (not all possible lines are) shown. Secretariat responsibilities are delegated.



This participatory action research aims to develop a healthy cities network resembling the model in diagram IV. In diagram IV 'S' should represent the core of the healthy cities network that will be the center of multi-level management linkage (MML) and function as one stop services for the prevention and treatmentof HIV/AIDS.

Diagram IV :



The network will have a central secretariat to facilitate linkage between members. The features of network will be integrated depends on the capacity of leaders and members of each nodes. After at the end of each project, participatory performance, assessment, monitoring, evaluation, will take place. (Thiengkamol, N.,2004).

Benefit of networks

Healthy cities networks orientated towards development provide benefits in several interrelated ways depending on specific objectives, membership and activities. Some immediate and rapid benefits for HIV/AIDS infected people in the network are likely to occur. Longer-term benefits become apparent as development and programmes become more effective, know-hows are transferred and systems evolve.

Benefits of networks can be summarised as follows (Starkey Paul;1997:20):

- Networks facilitate the exchange of information, skills, knowledge, experiences, materials and media, through meetings, workshops, publications and cooperative programmes. Sharing of skills and experiences increase the overall competence of network members, whether individuals or organizations.
- Network information exchange and coordination leads to less duplication of work and effort. With less duplication, faster progress and a wider overall impact should be possible.

- Network can effectively link people of different levels, disciplines, organizations and backgrounds who would not otherwise have an opportunity to interact. For example, they can bring together researcher teams, policy makers, staff, stakeholders and orphans for having policy and activities that support quality of life of AIDS orphans.
- Networks can create awareness among people and organization that they have similar concerns and face similar development challenges.
- Networks can provide the critical mass needed for local, national or international advocacy, action and policy change.
- Networks can help address complex development problems and issues that seem overwhelming to those working at village level.
- Network can bring together funding and technical cooperation agencies to those in need of resources and support.
- Networks can provide members with a source of peer support, encouragement, motivation and professional recognition. This can be particularly important to those outside the normal hierarchies of government, education and international research.

What the healthy cities network plan to do

We are committed to building healthy cities and have set up a "City Health Partnership" which will distill specific activities for improving the HIV/AIDS situation. These occur in 10 key domains: policies and strategies, education, health, nutrition, psychosocial support, family capacity, community capacity, resources, protection, and institutional care and shelter that need to be addressed and monitored at the national level. This is what we plan to do:

- Carry out a health and lifestyle surveys across the Mekong region.
- Develop a comprehensive City Health Profile to allow us to agree on the most important health needs within a city.

- Assess how policies and programs promote community cohesion and can build a vision of unity, citizenship, civic and community pride and then develop a network program to realize that shared vision.
- Develop a city health plan to tackle causes of ill-health and the 'health divide' (The 'health divide' between the rich and the poor continues to grow in this area .Our ability to be healthy depends on employment, housing, transport, local crime and safety problems, education, levels of poverty and how easy it is to get access to healthcare services in cities within the Mekong region).
- Improve health services in less well-off areas of the city.
- Improving health services for vulnerable groups such as homeless people, including better care and treatment for those infected or are affected by HIV/AIDS.
- Raise awareness about health issues and provide better and more accessible information and advice.
- Trying to reduce alcohol, smoking, and promote sufficient economies to the city people.
- Reduce the number of teenage pregnancies in the city and set up better social and educational support for teenagers and AIDS impacted people.
- Make sure that the most disadvantaged areas have a child center offering good quality childcare, early years education, health services and family support.
- Make sure that respite childcare is included in a package of support for vulnerable families.

- Work with community and voluntary organizations to set up and strengthen local groups for knowledge and positive attitude development about HIV/AIDS.
- Make sure that the needs of vulnerable adults, children and their families concerned about AIDS are identified and met, with their involvement.
- People should be empowered to interact and engage with the wider community and influence decision-making.
- Help break down barriers for AIDS prevention in areas such as gender, race, homosexuality (lesbian and gay), bisexuality and transexuality, as well as categorise HIV infected people into status, nationality, marital status, and employment. Networks can help to overcome such problems by allowing people and organizations (their nodes) to exchange information and experiences with those outside their working environment and cooperate with them in a legitimate and democratic way.

Expected Outcomes

- A healthy cities network will provide basic needs to people in the Mekong region who suffer from the impacts of HIV/ AIDS.
- People in the Mekong region have access to local health services that are easy to use, and find local solutions to community safety issues.
- A healthy cities network will be a package of services that meets a whole range of needs, so that people will not be passed from one agency to another.

- This network organization will provide one-stop services for the prevention of HIV/AIDS and problem solving from AIDS impacts. It will significantly contribute to the fight against HIV/AIDS because of pool resources strategies and the structure of the network that has been built up from multiple levels and dimensions.

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Cultural Context in the Lower Area of Mekong Region

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ABSTRACT

The objective of this research is to study the cultural context, tradition, way of life, belief, and local wisdom of people in the lower area of the Mekong River, and to determine the factors associated with the people's culture regarding natural resources and environmental conservation. The population consisted of population in the lower area of Mekong River. The sample size was determined by statistic method (Yamane, T., 1973). Therefore two cities are Mukdahan Province of Thailand and Kunthaburi of People Republic of Lao were selected. The descriptive statistic in term of frequency, percent, mean, and standard deviation were used. Chi-square test was used for the association.

The research findings showed that culture, tradition, way of life, belief, and local wisdom of people in the lower area of Mekong Basin River had association to the cities' characteristics, education, occupation, and age.

Recommendation, the results can be used as guideline for promotion, rehabilitation, and conservation of natural resources and development of environmental quality of Mekong Basin, especially, in the lower area to meet the sustainable development. Moreover it can be used as baseline data for planning for the healthy city projects.

Introduction

At the moment, plenty issues of globalization have been appeared in various levels whether global level, regional, national, and general social levels. It is obviously seen from the consumerism current of the world population. Teenage is the group of people who is easily influenced from different media. This makes devastation the fundament and root of the original culture and tradition in company with the advance of materialism. These attitude, perception, belief, and value changes cause tremendously exploited the natural resource and environment for better living with the over consumption than actual needs.

Moreover, lifestyles of humans are also changed. The rapid communication among countries even crossing over the continent, it makes the people from different parts of the world can communicate, receive and transfer the plenty of ideas, concept, knowledge, even though, culture, belief, tradition, value, perception, and so on within second or shorter. The world is narrow and the mind of humans is narrow too. Therefore, it should pay attention to the cultural strategies with regarding to environment and natural conservation which are the basic element for living. Moreover Culture and tradition is not happen according to the nature but it gradually accumulate of knowledge, experiences, local wisdoms, and lifestyles so it the property of the society.

From the investigations and reports revealed that the humans can maintain their ancestry lasting till now, and they do not become extinct like different creatures because human being has evolution in n different aspects through adaptation to live in the earth. Besides, it was found that the important factors that make the human to improve, and change the way of life to survive that is the environment and natural resources. They are the essential factors to sustain all living creature on the world because all living things and non-living are interdependent each other so if any element changes, it affects to the others as well.

The way of living of people on the Mekong Basin, from past to present, it still live with depend on the nature, particularly river is the important factor that

facilities to the nourishment, peace, and sustaining the ancestry. There are plenty of river in The South East Asia but Mekong River is an important river because it is International River that play an import role to numerous countries that are China, Thailand, Cambodia, Loa, Myanmar, and Vietnam, Therefore it has different local name when it flows through any local area of any countries, it is called in different names, nevertheless for the world wide calling, it is called Mekong River. When it flows through China, it was called Lhanchang River or Lanchang River (Part of Chima), Khong River, when it flows through (Lao area and upper part of Thailand) or Kong River, when it flows through (Lower area of Thailand), Tonlethom (Cambodia) and Ka-long river or Kao Mang Korn (Vietnam) and it called in others. This is noticeable that the different names of Mekong are called by local people due to the different of languages, cultures, belief, tradition, way of life of local people.

Mekong River is a longest river that its origin is ranges of mountain Himalaya. It flows passing different countries that 6 countries are China, Myanmar, Thai, Cambodia, and Vietnam. This makes the basin around it s two banks contained numerous resources, diversities of races, language, and culture. The population in this basin is bout 100 million peoples. Most of them are the original people that have long term of accumulation of culture, belief, tradition, way of life, and local wisdom since their ancestors. Moreover, there are plenty of adaptation occurred that makes the people to adjust themselves to be appropriate to their locality so it leads to the sustaining of human species (Viboon Leesuwan, 1997: 184-215).

From the different research works, various evident documents, and the results from the progress of technology, cause the numerous changes that affect to natural resources, environment, and lifestyles in the present. These make different stakeholders reconsider the importance of culture, tradition, way of life, and local wisdoms that are able to harmoniously live together with the humans. Especially, the people in the lower area of Mekong River, There is an interesting things to study whether the culture, tradition, way of life, and local wisdoms associated to the demographic characteristics of people live in the lower area of Mekong River.

Literature Review

The group of Mekong Bain cultures or Thai-Lao group is a group of Thai-speaking people since antiquity. This area ever was the land of Lan-Chang Kingdom. It was a rather grate kingdom that ruled by Chun Louy as the first king. The east boundary connected to China, Vietnam, and Cambodia. The west boundary connected to LAN-Na-Thai region and Ayudthaya Capital, Dong-Phaya-Fai Range, and Petchaboon range. The north boundary connected to Sib-Song Pun-Na region ing Yunnan Province of China. The south boundary connected to Chiang-Taeng city collated under Lhi-Pee Islet of Cambodia. The Mekong River located at the middle (Sujitt Wongthes, 1995: 1).

The relationship of people between both banks of Mekong River, there was a culture and tradition as indicators to point out that it had the similar origin. The relationship between social development and Lan-Chan culture were revealed that there was evident of fable, chronicle and temple that told about the temple construction, and various places of worship with the belief that was an authentic story with names of plenty people and place appearances such as chronicle of U-Rung-Ka-That, Pra-Bang, Pra-sak-Kum, Pra-Kaew, and Prathat-Luang for instance (Jaruwan, Thamwat, 1997: 62).

The relationship of people between both banks depended on The Heet-Sin-Song tradition as media for continuously practice. Therefore, the change of environmental context of nature and society affected to the ritual performance of The Heet-Sin-Song tradition (Pra Munu-Thanurit Duangdee, 2000: Abstract).

Lower area of Loa, the prior there were two groups of people that were Loa-Lum, and Lao- Thaeng ethnic groups. Loa-Lum lived in the plain area. Their earnings were rice farming on which transplanting of paddy seedlings is practiced, catching fish, doing basketry, living in a woody house, blowing reed organ, having Mho-Lum (northeast traditional dance) as recreation, eating sticky rice, playing to Buddhist region, Using the Thai-Lao language. They condense in Khwang Wasan-Na-Khet, Khwang Jum-Pa –Sak, and other main cities in order to earn with merchant and

governmental officers. For Lao- Thaeng, lived in the high land and mountain areas. Their earnings were rice farming by rotating style. There was different sub-tribe group but every sub-tribe had a shared special culture that were paying respect to ghost, smoking Kok, drinking jar alcohol, carrying the basketry on the back weaving the cloth with the hand loom tight at the waist, and using Mon-Khmer language (Supachai Singyabuth , el al, 2001: Abstract).

Belief means the acceptance, respect, or putting one's faith to something without reason to explain whether that it is able to be proved as a truth or not. That acceptance might be accepted by faithfulness or loyalty with scare. After generation by generation, the belief became the tradition of that tribe (Khunchai ApiSuphab, 2004: 3).

Supernatural thing means thing that is above reason. It can not use the scientific methods to examine or prove. Among the supernatural things, religion has the most influences over the northeastern people’s behavior, feeling and thought. The Buddhism religion is a principle for them but the practical way of ritual, they might have the Pham religion. Moreover, they still believe on the different integration of deva, god, or angle, ghost, spirit or holy things so the northeastern people have diverse beliefs such as destiny that were the good and the bad which one did in the past. This resulted from the good practice or practice according to Heet-Khong or twelve months tradition with belief that human is born to pay back his prior activity. It was divided into 2 phases that were the first phase started from past to present and the second phase will start from present to future time. Therefore, human being has a freedom to select to define the fate so most of the northeastern people do easily not accept lose or discouraged. They practice in the good performance because they belief they will get the good results in the future. Moreover, they also believe on Pha-Ya Tan who is the good in the heaven that build the world and everything in the world, including making the rain to fall in the right season, and providing the enrichment. Additionally, they believe on serpent thoroughly even the Buddhists, particularly, the people who lived in near the Mekong River both Thai and Lao people (Apisak Som-Intara, 1994: 89-164).

As whole viewing context of society, culture, tradition, and rite of the villages of northeast, it was found that the people belief on serpent is still alive and tight with their ways of life. Especially, the meaning and symbol of "Serpent" is still a house-ghost, ancestor-ghost, and farm-ghost that are the center of meaning of good relationship in the society (Kam –Pui Pol-Lue-Cha, 2000: 225-234).

From the various studies were done on beliefs of northeastern people, the findings revealed that their ways of life are fastened to the belief of Mae-Posop (Angle of rice), Ta-Hak ghost, farm-ghost, land-ghost, ancestor- ghost, house ghost, spirit, fate, black magic, and auspices. These make the northeastern people love their land and ancestor so they tight to their mother land (Boonsom Yodmalee, 2002: 123-128).

Suthin Sanongpun (1991: 135) explained that Ta-Hak ghost is part of Heet-kong tradition because it is added the group of belief that called "Heetpee-Kongjiang". The prohibition on Ta-Hak ghost is a part of decreasing the conflict of land of rice farming because they would not fight for land because Ta-Hak ghost defined the land owner. If anyone fight for land without the acceptance of owner, Ta-Hak ghost will punish them. Therefore this is a motivation of farm maintenance of farmer.

Belief on Pu-TA ghost (grandfather ghosts) is an origin of a demon has possessed one's soul so human can communicate to spirit and to propitiate (the spirits) by a sacrifice or offerings of food to spirit that had supernatural influence to favor and give benefit to them. The people annually perform the rite of ghost-nurture or pay for "Kai-Ba- Chao-Pu". This is a presentation of paying respect and faithfulness to grandfather ghost in order to ask them to protect them from various danger, and harmfulness to peacefully live and safe from diverse risks and sickness (Pensri Dook, 1993: 18-19).

The religion that Pu-Thai people that have paid respect that are the respect to ancestor-ghost and city ghost. The ancestor-ghost are grandfather ghost, grandmother ghost, father ghost and mother ghost due to the belief that after their ancestors died, they became to big snake or Ling-Lom (loris) to look after their children and grandchildren and the city ghost look after the people to peacefully live (Songkoon Chanthathorn, and Piti Saenkotara, 1997: 13).

The local wisdom of Pu-Thai people in the traditional medicine, got from plant, animal, and minerals to cure the diseases. It is a method and a process of continuous transferring their property from their ancestors with condition, particularly, they build the condition of fasten to the nature in term of dependency but not deterioration. With the belief that whether they destroy the nature in which way, the spirit in the nature of forest, mountain, tree, and river would get angry and punish them and they might them to be sick or died (Boonyong Katethes, 1993: 19).

Heet Sib Song or twelve months tradition is word used for calling the tradition of people the northeastern or I-Sarn that means the traditions that people perform in different occasions during twelve months of the year. It is influenced by the Buddhist religion and is transferred from their ancestor to the next generations. It has been accounted as a type of culture that crates a identity and expresses to the gloriousness of nation or it is a meaningful of the Thai race so it makes Thai people feel arrogant to their nation and it assists to support the existing of Thai nation (Sarn Sarathatananont, 1987: 1).

“Heet” is a Laotian language and it derived from the Bali vocabulary that used “Jaritta” (it is read as Ja-Tid-Ta). Then Lao people and Thai I-Sarn used in term of “Jaheet”. Afterward the The word “Ja” is cut so it became “Heet” (Boonkerd Pimpvoramethakul, 2001: 1).

Pla Buek (Pangasianodon Gigas or Chevey) is the biggest fresh fish in the world. Its origin is only in Mekong River and it is important to the people way of life in the community. From the color drawing before history at Pa-Tam, Ubon Ratchathani Province, the archeologist assumed that big picture was probably a picture of Pla Buek. The people of Krai beach and I-Sarn people believed that Pla Buek has a water good or dam good to protect, therefore to fishing the Pla Buek must to arrange the rite to pay for good to ask permission. Chinese believe that it one eat the Pla Buek, then one will be clever like “Khong-Beng” (one of the philosopher in the Three Kingdoms Story). Lao and I-Sarn people also believe that one eat the Pla Buek, one is a favorable fate and good luck.

At currently, there is still fishing for Pla Buek in the Cambodia, but in other localities such as Ubon Ratchathani Province to Lhuang Pra Bang , It finishes to fish Pla Buek due to the change of state of geographical feature. That make the shallow water so Pla Buek can not live because it likes the water that deeper than 10 meters. Moreover, there are a lot of islets occurrences to obstruct the Pla Buek fishery. Therefore, Had Krai village, Chiang-Khong District, Chiangrai Province is only a place that is still fishing for Pla Buek. There is annually rite performance between April, 17-18, the Mhor (people who perform the rite) who perform the rite must be a good person, and moral people that earns with the honest career and he must be a Buddhist so he will be old hunter with knowledge and understanding that received from his ancestors generation by generation. Besides, he must practice himself to follow disciple by do not eating ten Mung-Sung and fruits of the palmyra palmnot, and walk under the cloth drying rod and banana tree with a group of banana, and do not eating in the funeral ceremony food.

The rite for Pla Buek fishery is happened from the thought of Krai beach people with belief that everything that exist in the nature such as tree, mountain, river, and wild life. All of these have the good or ghost to protect so if any performance will be done, therefore they must perform rite. The natural and environmental state can be observed for the appearance of Pla Buek is the characteristics of plant at the bank of Mekong River such as Bohd tree in front of Had Krai temple will fully spring the green leaves and Peacock Flower, or Royal Poinciana will spring with red color flower, additionally, Kai Num vegetable will grow along the rock in the Mekong River will be welcome for visiting of Pla Buek. The level of water will raise high as nature. Seagull birds will fly from the south and fly through the north of Had Krai village for 3-4 days then it will fly back. Few day afterward, the crowd of fish (Pla Lerm or Pla Thepa callede in Thai) or fish of species Pangasius Sanitwongsei or H.M. Smith) will appear before Pla Buek respectively. It is obviously seen that the rite of Pla Buek fishery is rapport to the nature and environment. From the statistical reports during the year 1986-1998 showed that the Pla Buek was caught fewer and fewer. It might be due to two reasons that the fishery tools is more effective, and impact caused by dam construction of different countries destroyed the natural habitat

of Pla Buek and obstruct the route of migration for egg lay (Jaruwan Thammawatra, 1997: 103-129).

Mekong River is counted as blood of Baru people of Werk Buek village, Kong Jiam District, Ubon Ratchathani Province because they have used for earning place since their ancestor time. Fishery has been their main occupation that is Pla Buek fishery. The rite and value about Pla Buek fishery has been existing for long time. The Baru people belives that Pla Buek has the good or supernatural thing to protect so the first Pla Buek caught would be delivered back to the river. The second catching the same Pla Buek will be kept because they belive that this Pla Buek is the time to die (Jitrakorn Pothi-Ngam, 1993: 86).

In the past, when environment was mentioned, it was considered to the things that existed in the nature such as forest, river, water way, stream, canal, brook, creek, swamp, reservoir, marsh, and mountain. These provide the benefits to human being according to the way of life in each community, society, and locality in different aspects such as living, peace, beauty, and leisure, including everything that are beneficial for dally life. This is relevant to the statement that “Forest is Nature” (Rapee Sakrik, 1998: 7-11).

But at the moment, it is changing, since the various changes in the world is occurred both from nature and development of human. Majority of them develop in the material aspect more than others so it losses a balancing. It is obviously seen from the results of industrial revolution in Europe. The atomic bomb was dropped to Hiroshima city, Japan in the Second World War. Construction of atomic power plants for electricity generation and dam construction in different region are done for facilitate to humans. In particular, the Republic of China announced to bomb the islets at middle of Mekong River for dam construction (Suwapong Chanpungpetch, 2004: 2). Moreover, the another importance is to construct the giant dam at the middle of Yang-See-Kiang River that makes the people over all Asia and other sector are worry what will happen in the future. Especially, the natural environment is always violated and neglected, since a majority of governments pay no attention to this issue but they are interested in economic benefit more than concern to the global ecosystem.

Therefore, the changes happen in the worse direction, mainly most of people have no change to know and perceive on the unavoidably consequent danger.

However, the social and economic development must go on so the Thai society is increasingly facing with different problem. More than ever, the expanding economy based the global marketing and material development without the root of original culture of Thai society, the existing stage causes the overlooking for moral and ethic, particularly, politic, economic, governmental societies, and other institutes of all careers. These make the less opportune people lacks of assurance, and supporter, and they confuse, subsequences are broken family, disrupted society, and degraded culture.

Human being is social animal to unite as a group and has the social relationship each other that make human differ from animal that is ability to learn and systemic usage of language, and communicable sign. These make the human have higher ability than other animals because they are able to learn anything to be used as tools for living while human is able to construct the pattern of learning and living together that called “Culture” and the importance is human culture that it changes all the time. The most dominance of human is learning potential that able to construct the culture to living together. It dose not threaten the nature but is able to live with nature and adapt the culture go along with the natural change. The culture has a rapid change by staring with depended on nature of human to become to control nature currently. Some people thought with the point of view that people construct the culture not only for living of themselves and ancestry but also destruct themselves and world because there is no creature that can destroy human like human. It is obviously seen from the natural resources and environment degradation. Therefore, they are affecting due to plenty of pollutions impact. This leads the suffering to human itself like as Thai Proverb said that “Not be able throw the snake from the neck” (Prawej Wasi, 2004: 239-242).

Study the culture in the environmental matter is an interesting issue since the current of self-waken about the global environmental problems such as global warming or green house effect. Loss ever green forest impacts to the global

biodiversity leads to environmental conservation in Thailand both the middle class citizen in the urban, and people in rural area who has the way of life linked with nature and they directly receive the impacts (Surichai Whankaew, 2004: 85).

Vinai Veerawatananont (1994: 30-101) interestingly mentioned that there is a connection of culture, natural resources and environment. The environment has occurred and evolved for millions years since the soil, water, and air are the original substances of all living creature and non-living things. The different among these factors determine that there is a diverse pattern of life. The various forms of natural resources utilization and different living activities are parts of human culture.

Culture means the pattern of natural resources utilization. The environment and natural resources in each locality or different time are different. Therefore the culture will be diverse according to each region or locality. Sometime, in the same locality but in the different time, the culture is variable as well. Therefore the culture is dynamic not in statistic state or sustainable for ever. However, at present, the way of life or culture is changed with the influences of diverse developments in different forms such road, electricity, pipe water, transportation, communication, and career for instance. These cause the change and relate to the general environmental situation including social change, family structure, belief, and attitude of people.

While, there is a voice to call back for the culture, which is an identity of Thai way of life in the past. But the nature and environment have already changed by people behavior and socialization. These destroyed the nature, environment and culture without intention or indirect. Nevertheless, culture is dynamic like as human life. It is as naturally being and finishing because culture is not occurred by environment and nature but it is an imitation of other locality or society. The foreign culture sometimes destroys the local culture and life quality as a whole.

Culture, belief, tradition, way of life and local wisdom are the answers of appropriate support but to answer or only give the answer will be generally accepted it takes time or it needs more experiences before it will be perceived, acknowledged and accepted so they will change their value to perform proper behavior, then they will

conserve the natural resources and environment to meet the sustainable development (Surichai Whankaew (2004: 85-135).

Methodology

The research design is implemented according to the following steps:

1) The research survey was done to investigate the culture, tradition, belief, and local wisdoms of the population.

2) Tools are the questionnaires for data collection about culture regarding tradition, way of life, and local wisdoms.

3) The questionnaires were used to determine the reliability of each question and the whole documents with determination of the alpha coefficient (α-coefficient) (Sproull, 1988).

4). Population and sample, the sample was 60 peoples who live on the bank of Mekong River, Mukdahan Province, Thailand and Muang Kunthaburi, Khang Sawannaket, People Republic of Lao. Sample was collected by simple randomization technique.

5). For the part of questionnaire on culture regarding tradition, belief, and local wisdoms; the Likert's scale with five levels was used (Suchart Prasith-Rathsinth, 1995: 166-169).

6. Descriptive statistics, including frequency, percentage, mean and standard deviation were described and Chi-Square test was used to determine the association between demographic characteristic of sample and culture, tradition, belief, and local wisdoms.

Research Results

The characteristic of sample group, Thailand had the mean of age is 43.83 years. Most of them was 50-59 years old with 30 percent, subsequences were 30-39 years with 20percents and 20-30years with 16.7 percent respectively. Most of them was female with 60.0 percents, and the marital status was couple with 63.3 percents, Their education level was at primary school level or lower with 40.0 percents, secondary

school or high school level with 36.7 percents. Most of their occupation was merchant with 63.3 percent. Their income mean was 11,298.67 Baht per month.

The characteristic of sample group, People Republic of Lao had the mean of age is 34.87 years. Most of them were 30-39 years old with 40 percents; subsequences were 20-29 years with 30.0 percents and 50-59 years with 13.3 percents respectively. Most of them were female with 53.3 percents, and the marital status was couple with 66.7 percents, their education level was at secondary school or high school level with 66.7 percents, primary school level with 16.7 percents. Most of their occupation was merchan with 33.3 percent and business 23.3 percents. Their income mean was 6383.33 Baht per month Table 1.

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic Categorized according to general characteristics

Description	Thailand		People Republic of Lao	
	Number	**Percent**	**Number**	**Percent**
General Characteristics				
Sex				
- Male	12	40.0	14	46.7
- female	18	60.0	16	53.3
Total	30	100.0	30	100.0
Age				
- ≤ 19	2	6.7	1	3.3
- 20-29	5	16.7	9	30.0
- 30-39	6	20.0	12	40.0
- 40-49	4	4	3	10.0
- 50-59	9	9	4	13.3
- ≥ 60	4	4	1	3.3
Total	30	30	30	100.0
Thai Mean= 43.83 S.D= 17.09 Mod =17 Min=17 Max=83				
Lao Mean= 34.87 S.D= 11.14 Mod =28 Min=18 Max=60				

Religion				
- Buddhist	28	93.3	30	100.0
- Christ	2	6.7	0	0
Total	30	100.0	30	100.0
Marital status				
- Single	7	23.3	8	26.7
- Couple	19	63.3	20	66.7
- Widow	2	6.7	2	6.7
- Separate	2	6.7	0	0
Total	30	100.0	30	100.0

Table 1. Percent of sample group of Thailand and Lao People's Democratic Republic Categorized according to general characteristics (Continued)

Description	Thailand		People Republic of Lao	
	Number	**Percent**	**Number**	**Percent**
Education level				
- Illiteracy	1	3.3	4	13.3
-Primary school level or lower	12	40.0	5	16.7
-Secondary school to high school levels	11	36.7	20	66.7
- Diploma degree level	3	10.0	1	3.3
- Bachelor degree level	3	10.0	0	0
Total	30	100.0	30	100.0
Occupation				
- No occupation	3	10.0	4	13.3
-Agriculture	0	0	5	16.7
- Merchant	19	63.3	10	33.3
- Business	5	16.7	7	23.3
-Governmental, state enterprise, private	2	6.7	2	6.7
officer	1	3.3	2	6.7
- General hire	30	100.0	30	100.0
Total				
Thai Mean= 1,1298.67 S.D= 1,2807.98 Mod =5,000.00 Min=0 Max=55,000.00				
Lao Mean= 6,383.33 S.D= 9,764.68 Mod =2,000.00 Min=500.00 Max=50,000.00				

The finding indicated that the association between culture of lower area of Mekong Region and the education level, occupation and age showed in table 2. It can be concluded as following details.

1. The association between culture of lower area of Mekong Region and cities characteristics regarding the conservation of forest resources and environment were as follows:

1) The belief and tradition had the association to cities characteristics with statistically significant at level of 0.01 in the following issues:

-Belief on maintenance for Don Pu Ta and sacred place, the grandfather ghosts will protect their children and grand children who conserve the tree and the Pha-Ya Tan will punish the one who destroy the nature.

- Belief on house ghost, ancestor ghost, and grandfather ghost exist and play role in protection for village and community. Human, and animal died and have a birth again according to the good and bad performance.

-The tradition of forest ordained is a mean of forest conservation.

2) Belief, way of life, and tradition had the association to cities characteristics with statistically significant at level of 0.05 in the following issues:

- Boundary of temple, religion places, and Don Pu Ta are the sacred places for conservation of tree and forest.

- Boundary of Don Pu Ta, giant tree, ruin temple, and other religion places, one who destroyed the tree and others will be punished.

-Belief on Pee Ta Hak, farm ghost, forest ghost, mountain ghost, and sky ghost will punish one who destroyed the environment and natural resource.

-Belief on the existing of hell and haven, therefore people should not take advantage from others and support each other.

-Culture of take all rice and not left rice will help to conserve the natural resources.

-Tradition of sustain fate of Mekong River is a guideline of environmental conservation of Mekong River.

2. Culture o lower area of Mekong Region and educational level regarding natural conservation as following issues:

1) Belief, way of life, and tradition had the association to education level with statistically significant at level of 0.01 in the following issues:

- Monk is able to lead and to develop the community to conserve the forest.

-Temple or religion and Don Pu Ta are the place of tree and forest conservation if the people enter to these places and destroy the tree, they will be punished.

-Belief on the existing of hell and heaven, human and animal died and are born according to the good-bad performance; therefore people should not take advantage from others and support each other. Moreover, the natural things can provide advantage and disadvantage to human being.

-Nurture the ancestor ghost, father ghost, and mother ghost will create the good relationship within family and they will help to conserve the natural resources and environment.

2) Belief, way of life, and tradition had the association to education level with statistically significant at level of 0.05 in the following issues:

-Belief on maintenance for Don Pu Ta and sacred place, the grandfather ghosts will protect their children and grand children who conserve the tree and the Pha-Ya Tan will punish the one who destroy the nature.

- Pee Pu Ta, giant tree will only protect the children and grandchildren who conserve the trees.

-Belief on Pee Ta Hak, farm ghost, forest ghost, mountain ghost, and sky ghost will punish one who destroyed the environment and natural resource.

-House ghost, ancestor ghost, and grandfather ghost play role in protection for village and community.

-Traditions of boat race and blaze boat flowing (Khaeng-Rua and Lhai-Rua-Fai) should be conserved because it help to realize the value of river.

3. Culture o lower area of Mekong Region and occupation regarding natural conservation as following issues:

1) Belief, way of life, and tradition had the association to occupation with statistically significant at level of 0.01 in the following issues:

- The giant tree is living place of the deva or ghost so it should not be cut off.

- Mekong River is a site of food/ agriculture/ way of community.

-Traditions of boat race and blaze boat flowing (Khaeng-Rua and Lhai-Rua-Fai) should be conserved because it help to realize the value of river.

2) Belief, way of life, and tradition had the association to occupation with statistically significant at level of 0.05 in the following issues:

- Pha-Ya Tan will punish the one who destroy the nature.
- It should conserve tradition/ occupation of Pla Buek fishery.

4. Culture o lower area of Mekong Region had the association to age regarding natural conservation with statistically significant at level of 0.05 in the following issues:

- Monk is able to lead and to develop the community to conserve the forest.
- Boundary of Don Pu Ta, giant tree, ruin temple, and other religion places, one who destroyed the tree and others will be punished.

Table 2. Analysis the Association between General Characteristic and Culture of Sample Group of Lower Are of Mekong Region

Culture of Sample Group of Lower Are of Mekong Region				
Description	**Chi-square**			
	C. C.	**E. L.**	**Occu**	**Age**
Temple or religion is the place of tree and forest conservation.	0.02*	0.00**	0.10	0.10
Monk is able to lead and to develop the community to conserve the forest	0.20	0.00**	0.28	0.04*
Boundary of Don Pu Ta, giant tree, ruin temple, and other religion places, one who destroyed the tree and others will be punished.	0.02*	0.24	0.59	0.02*
The maintenance for Don Pu Ta and sacred place, are the tree and forest conservation.	0.00**	0.57	0.51	0.30
Pee Pu Ta, giant tree will only protect the children and grandchildren who conserve the trees	0.00**	0.05*	0.51	0.13
One who destroys tree or things in Don Pu Ta, one will be punished by Pee Pu Ta.	0.03*	0.00**	0.44	0.61
Belief on house ghost, ancestor ghost, and grandfather ghost exist.	0.00**	0.00**	0.73	0.53
Belief on Pee Ta Hak, farm ghost, forest ghost, mountain ghost, and sky ghost exist and will punish	0.01*	0.03*	0.32	0.87

one who destroyed the environment and natural resource.				
Nurture the ancestor ghost, father ghost, and mother ghost will create the good relationship within family and they will help to conserve the natural resources and environment.	0.11	0.00**	0.73	0.78

Table 2. Analysis the Association between General Characteristic and Culture of Sample Group of Lower Are of Mekong Region (Continued)

Description	Culture of Sample Group of Lower Are of Mekong Region			
	Chi-square			
	C. C.	E. L.	Occu	Age
Cut of tree in the boundary of temple or religion places, it means that they do not pay respect to sacred things.	0.38	0.27	0.90	0.82
The tradition of forest ordained is a mean of forest conservation.	0.01**	0.41	0.24	0.82
Belief on the existing of hell and haven, therefore people should not take advantage from others and support each other.	0.04*	0.00**	0.12	0.83
Human, and animal die and are born again according to the good and bad performance.	0.00**	0.00**	0.59	0.73
The natural things can provide advantage and disadvantage to human being.	0.04*	0.00**	0.24	0.52
Pha-Ya Tan will punish the one who destroy the nature.	0.00**	0.05*	0.04*	0.35
House ghost, ancestor ghost, and grandfather ghost play role in protection for village and community.	0.00**	0.03*	0.31	0.24
It should conserve tradition / occupation of Pla Buek fishery.	0.44	0.16	0.03*	0.56
Don Pee Lhuang is the natural site for breeding of Pla Buek so it should be conserved.	0.20	0.67	0.15	0.27
The giant tree is living place of the deva or ghost so it should not be cut off.	0.03*	0.41	0.00**	0.22
Culture of take all rice and not left rice will help to conserve the natural resources.	0.03*	0.08	0.54	0.59
Tradition of sustain fate of Mekong River is a guideline of environmental conservation of Mekong River.	0.03*	0.45	0.45	0.72
Mekong River is a site of food/ agriculture/ way of community.	0.16	0.14	0.00**	0.49

Table 2. Analysis the Association between General Characteristic and Culture of Sample Group of Lower Are of Mekong Region (Continued)

Culture of Sample Group of Lower Are of Mekong Region				
Description	**Chi-square**			
	C. C.	**E. L.**	**Occu**	**Age**
Traditions of boat race and blaze boat flowing (Khaeng-Rua and Lhai-Rua-Fai) should be conserved because it help to realize the value of Mekong River.	0.39	0.02*	0.00**	0.30
Tradition of Pay respect to Buddha' relics (Pra-That) will support for natural resource and environment conservation.	0.35	0.82	0.09	0.87
Conservation of twelve months tradition (Heet-Sib-Song, Khong-Sib-Si), it indicated that human recalled favor or service performed of natural resources/environment.	0.06	0.14	0.16	0.78

** P < 0.01, * P < 0.05

(N.B. C.C.=City Characteristics, E.L. Education Level, And Occu=Occupation)

Discussion

From the research findings, it can be concluded that the culture regarding to the natural resource and environment conservation are as follows:

1. In the belief aspect, the people who live in the lower area of Mekong Region will believe on sacred place, spirit, ghost, and supernatural things as following issues;

1.1 Belief on the sacred place such as Don Pu Ta, ruin temple, and land of temple, it is obviously seen that the tree or forest in these places will be flourish and be conserved.

1.2 Belief on Pee Ta Hak, farm ghost, forest ghost, mountain ghost, and sky ghost, it is obviously seen that existing of ghost room and ghost shelf in the house. These cause the people who pay respect or children and grandchildren will properly practice, particularly regarding natural resource and environment conservation.

1.3 Belief on the religion leader such as monk, Tao Jum or the elderly people in the community, it is obviously seen that these persons play role as leaser in different facets in the community.

1.4 Belief on the existing of hell and haven and cycle of death and birth, it is obviously seen that the people will present the food to monk and properly practice and they do not destroy the natural resource and environment.

2. In the way of life aspect, the people who live in the lower area of Mekong Region will perform their way of life as following issues;

2.1 In the Agricultural occupation aspect, it is obviously seen that the majority of people in the communities still depend on the nature.

2.2 For the fishery occupation such as tradition of Pla Buek fishery, it is still an occupation, which depends on the nature since there is a season of fishing. The giant fish will be only fished so it is a mean of natural resource and environmental conservation.

3. Tradition and natural resource and environmental conservation aspect.

3.1 tradition about water such as boat race, fired boat flowing, Loy-Kathong (banana leaf bowl), it implies that these traditions represent for the thankfulness of people to river so these make the people who live at the area of Mekong River is fasten to it. Therefore, they perform the properly behavior to maintain and conserve the environment around the river to be in good condition.

3.2 Tradition about rice such as Boon Koon Lan, Su Khun Khao, Boon Khao Sak, and Boon Khao Pra Dub Din, these are all make people to recall for the favorable of rice to farm and people who eat rice as main dish.

3.3 Tradition about forest conservation such as to leave offerings for the priests, and to ordain forest.

3.4 Tradition about soil such as Pithee Hak Na, sand mountain building, and sand moved to temple.

Recommendations

From the research results, the findings showed that culture, belief, tradition and way of life of people at lower area of Mekong Region play a role to assist natural resource and environmental conservation as follows:

1. The twelve months tradition, boat race, fired boat flowing, Loy-Kathong

(banana leaf bowl), Boon Koon Lan, Su Khun Khao, Boon Khao Sak, Boon Khao Pra Dub Din, to leave fferings for the priests, to ordain forest, Pithee Hak Na, and sand mountain building will make people to perceive the importance of natural resource and environment.

2. Belief ob sacred things in the issues of Pee Ta Hak, farm ghost, ancestor ghost, forest ghost, mountain ghost, and sky ghost, these make people who pay respect will fear and respect so they will not destroy the forest. Additionally, they will cooperate to conserve natural resource and environment.

3. Way of life with the simply living of people in this area, are agriculture, fishery, and business. Moreover, it should be promoted on self-sufficient agriculture.

4. Belief on religion, most of people who live in the river bank will pay respect to Buddhism. The Brahman religion plays influence. The people believe on the cycle of death and birth, and hell and heaven. If they sticky practice to principle of religion, they will be happy and the environment will not be thoroughly exploited and damaged.

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