Migration and Health Impacts among Low-skilled Labors in the Greater Mekong Subregion

Keoamphone Souvannaphoum

April 2008

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Keywords: Migration, health, low-skilled labors, mobility, vulnerability

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ABOUT MEKONG INSTITUTE

The Mekong Institute (MI) is an inter-governmental organization working in the six Greater Mekong Subregion (GMS) countries (Cambodia, Lao PDR, Myanmar, Thailand, Vietnam and Yunnan Province of China) to provide capacity building activities for government officials, members of private enterprises and civil society involved in the development of the subregion. MI has been serving the human resource development (HRD) needs of the GMS since 1996. The New Zealand Government conceived Mekong Institute as a development assistance project for the countries of the GMS, intended to evolve into a regionally governed, autonomous institution. The institute is situated on the campus of Khon Kaen University in Northeastern Thailand. NZAID, the Thai Government, Khon Kaen University and other national and international partner agencies funded this project from 1996-2003.

In 2003 the six GMS governments signed a charter founding MI as a non-profit, autonomous organization, working in close collaboration with other GMS institutions. On July 17, 2007, the Thai Cabinet approved MI Headquarters Agreement to recognize MI as an intergovernmental organization. With this intergovernmental status, MI is now in a very favorable position to facilitate regional development, cooperation and integration through its human resource development programs, GMS-focused action researches, and policy dialogue facilitation.

MI works closely with the governments of the six GMS countries in designing and delivering high quality and relevant human resource development programs. The capacity building activities include learning programs, special focus learning forums (policy dialogue), and GMS focused research in areas of GMS high priority development needs identified by the stakeholders. To support GMS focused research activities, MI has started an in-house research capability by establishing the Research and Learning Resource Department. At the beginning of 2006, MI formed the Mekong Institute Research Advisory Committee (MIRAC) to coordinate the researches in the respective GMS countries. The aims of this research profiling are, to bring together researchers from the GMS countries as well as researchers from non-GMS countries to initiate research networking and participate on collaborative research activities on GMS related topics. MI has currently at least 2,700 alumni throughout the GMS and beyond and 42 staff at the headquarters in Khon Kaen, Thailand.

MI Strategic Goals in the next three years include, providing services to the six GMS countries in Capacity Building for Regional Cooperation in four thematic areas which have been approved by the MI Council in July 2007.

1. Public Sector Reform and Good Governance
   a. Leadership in Public Service Reform
   b. Leadership in Competitive Enterprise
   c. Donor Assistance Management and Aide Effectiveness
2. Rural Development and Project Management
   a. Transboundary/Regional Project Management
      i. Project Feasibility and Design
      ii. Project Planning and Development
      iii. Project Execution, Implementation, and Reporting
      iv. Results-based Project Monitoring and Evaluation
   b. Rural Development
   c. Income Generation and Poverty Reduction

3. Trade Facilitation and SMEs Development
   a. Enhancing Entrepreneurship
   b. SMEs Cluster Development and Export Consortia
   c. Trade and Investment Facilitation

4. Regional Cooperation
   a. Tourism Approach to the Regional Development
   b. Human Migration Management
   c. Conflict Management for Effective Regional Cooperation
   d. Economic Corridor Social Impacts Mitigation and Management
   e. Strategic Human Resource Development for Effective Regional Cooperation

MI Human Resource Capacity

1. Sixteen professional program staff (specialists and facilitators)
2. Eight program support service/event organizers
3. Eight administrative support personnel
4. Ten Young GMS Professionals

MI Facilities

1. Two conference rooms fully equipped with audio-visual equipment and training materials
2. Twenty-four hour internet services through wireless system
3. GMS Document Center with online access to Khon Kaen University Library
4. Thirty-eight standard hotel rooms with twenty-four hour internet access.

MI Competitive Advantage

The most valuable and strongest competency of MI is its avowed focus on the GMS. This includes
1. the access that MI has to officials and organizations throughout the GMS
2. out access to over 2,700 alumni and national coordinating agencies of the GMS, and
3. our regional focused human resource development programs.
Mekong Institute in the Joint Summit Declaration of the 3rd GMS Summit, Vientiane, Lao PDR on 30-31 March 2008

Leaders of the six GMS countries met in Vientiane, Laos on 30-31 March 2008 to discuss the progress and chart future directions in GMS cooperation. The triennial meeting, the third among GMS Leaders, had its theme “Enhancing Competitiveness Through Greater Connectivity” and aimed to sustain and deepen economic cooperation and integration efforts among the countries in order to better meet development challenges and realize common vision of an integrated, harmonious and prosperous subregion.

Plan of Action for GMS Development, 2008-2012
Source: (http://www.adb.org/Documents/Events/2008/3rd-GMS-Summit/default.asp)

Human Resource Development: Implement the new strategic framework and action plan for cooperation in education, health, labor, and other social development areas, broaden and deepen the scope of the Phnom Penh Plan for Development Management, support the mandate and mission of the Mekong Institute, and enhance the prevention and control of communicable diseases in border areas.

Photographs of the Activities of the Mekong Institute

Photos: Left (GMS Policy dialogue) and Right (Training/Seminar) at MI Residential Building

Photos: Left (Group presentation in training program) and Right (MI Learning Resource Center)
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Mekong Institute Research Advisory Committee (MIRAC) consists of a total of eleven members and representatives; six GMS researchers, three international advisors, Director and Research Manager of the Mekong Institute. The objective of the MI Research activities is to establish research profiles/research culture and implement GMS focused researches through MIRAC and GMS researchers. The specific purpose of MIRAC is to initiate collaborative and individual country researches among the GMS countries; to build in-house research capacity of MI and GMS researchers; and to promote MI as learning and research resource oriented institute.

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Regional Policy Dialogue of the Greater Mekong Sub-region
Through Mekong Institute with the support of the Rockefeller Foundation

Greater Mekong Subregion (GMS) countries face many challenges such as poverty and limited national and regional infrastructures for transportation, electricity, telecommunications, health and education. The average income (approx. US$800) is 20 percent below the average income of developing Asia. The income distribution is widely disparate between rich and poor, and the urban and rural populations. In order to take advantage of the opportunities for economic development as a region, large regionally integrated infrastructure projects are key. Geographic realities and dependencies necessitate cooperative management of natural resources and preservation of the environment.

The governments of the Greater Mekong Subregion are convinced that increasing cooperation is vital to their development needs. In 1996, these six governments agreed that the GMS would be the primary framework for economic cooperation. During the past five years the GMS has been increasingly involved in integrated major regional development programs and projects. The subregion has attracted major funding partnerships from regional and international organizations, with the Asian Development Bank (ADB) acting as the coordinator for regional development support. Twelve years into the GMS cooperation, not only have large integrated infrastructure projects progressed, but general economic cooperation has also increased to a significant level, with trade facilitation, cross border investments and economic linkages expanding rapidly.

The goal of the GMS from its inception was to promote both economic and social development by strengthening economic linkages. Much has been accomplished in the development of economic cooperation and integration, to mutual benefit of the GMS member countries, and now it seems that the time and circumstance call for increased attention to addressing regional policies and programs vital to social development. In the November 2002 Joint Summit Declaration, the substantial fruits of economic cooperation were acknowledged, and commitment was made to taking steps to address common challenges in social welfare of the people in the GMS, to lay the foundation for social progress. The GMS leaders committed their governments to addressing social development needs through cooperation. They noted the need to address regionally the circumstances crippling the development of human potential and the need for protection of women, children, minorities and other vulnerable segments of society from abuse and discrimination. They made a call for regional policy making and cooperation to combat illegal cross border trafficking/trade of drugs and humans, and also to combat the spread of disease and other health hazards.
The ADB Strategies Framework for the Next Ten Years emphasized that although the first 10 years of GMS cooperation has brought much progress in infrastructure and economic development, there are social development issues that would benefit greatly from a regional approach to policy making. Areas cited for regional policy making were health, education, labor and rights of migrant and cross border populations, as well as the access to social services for ethnic populations in mountainous and remote areas.

Once of the most important achievements cited by the GMS Summit leaders, the ADB and other GMS development partners is the growing trust and confidence in the countries’ cooperation. This trust and improvement in relationship is perhaps the most important accomplishment of the GMS cooperation efforts so far and creates an environment now that is conductive to cooperation and integration in the formulation of regional social policies.

In order to promote this regional policy formulation for social development, there is a need for forums to facilitate and stimulate regional policy discussion in areas of social concern. These forums would enable policy makers, civil society and others with expertise relevant to the policy issues to come together in a participatory learning environment to formulate solutions to regional problems. The learning environment would need to be information rich, with access to pertinent research and facilitation in applying research and information to the collaborative formulation of regional social policies.

The regional policy dialogue program initiated by Mekong Institute with the support from the Rockefeller Foundation partly fulfills the Mekong Institute’s objective to contribute to policy thinking on key issues affecting the region through a series of policy meetings. These meetings serve as venues for dialogue and exchange among GMS senior policy makers, civil society groups and development agencies on trans-border issues that have emerged or evolved into more complex forms due to infrastructure and other key developments, in the process of economic and spatial integration in the region.
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ACKNOWLEDGEMENTS

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CARAM</td>
<td>Co-ordination of Action Research for AIDS and Mobility</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GMS</td>
<td>Greater Mekong Subregion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>STDs</td>
<td>Sexual Transmitted Diseases</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>3D</td>
<td>“dirty, dangerous and difficult”</td>
</tr>
</tbody>
</table>
ABSTRACT

Linkages between migration and health have been one of the greatest challenges in the Greater Mekong Subregion. Migration across health exists among the population’s countries of origin and destination. In the GMS, health is still one of the lowest development indicators particularly for developing countries. For origin and destination countries, population mobility determines the factor contributing to the existing health indicators and potential spread of communicable diseases because of the lack of available protection mechanisms. For migrants, the mobility status, disparities in health access, couple with lack of supporting policies and attitudes put them at higher risk and vulnerable to many health problems. Incidences suggest that health concern of migrants is growing at an alarming rate while statistics over health diseases among migrants’ population are high and increasing. The negative health outcomes resulting from migration and population mobility will not only create long-term effects on migrants’ health and their families but also public health planning and development as a whole. This paper seeks to review the health impacts among low-skilled labors during different stages of their migration and gaps of policies involved in the Greater Mekong Subregion countries. The study includes qualitative data collection of Cambodia, Lao and Vietnamese migrants working in Cambodia, Laos, and Thailand. This study seeks to gather support for improving health related quality lives of those who experience the hardest as a result of the migration in the Greater Mekong Subregion. The results aim at promoting awareness and advocacy for concerned governments particularly the Ministry of Labor and Social Welfares to address some of the key challenges associated with migrants’ health and welfares.

Keywords: Migration, health, low-skilled labors, mobility, vulnerability
Migration and Health Impacts among Low-skilled Labors in the Greater Mekong Subregion: A Case Study

Keoamphone Souvannaphoum

1. Introduction

With over two million migrants moving around Greater Mekong Subregion (GMS), the process of migration has threatened public health and well-being of the population in the region at large. The interaction between migration and health varied among many factors. Health problems among migrants are believed to be influenced by both conditions at origin and destination countries. At countries of origin, health problems are related to socio-economic and cultural background, health history, quality of healthcare, and health accessibility. At destination countries, health problems are related to physical housing and conditions, health accessibility, and types of work migrants involve.

In the GMS, the socio-economic influences and population movement around the countries can be significant influences in terms of upholding the differences in health outcomes among the population at both origin and destination countries. Although a number of migrants move to countries where general quality of healthcare and services are better, migrants do not always find themselves in better health conditions at destination countries. Disparities in many factors including economic pressures, working conditions, and other factors often hinder them from accessing the required healthcare and services.

Risk factors among health concerns including communicable and non-communicable diseases are enormous. Often times, migrants at destination countries experience substandard living and working conditions, low health access and increasing health risks.

1 Consultant, Mekong Institute, Khon Kaen, Thailand, email: keoamphone@gmail.com
5 Applied to large-number cases of migrants from Cambodia, Laos, and Myanmar to Thailand.
These factors often contribute to determining health related vulnerabilities. Implications on health problems pose long-term affect on migrants’ health; their families’ well-being and the environment surrounding them. The effects on health threaten the public health planning and poverty in the region.

In response to the magnitude of this problem, a number of interventions have been implemented by the GMS governments and other concerned stakeholders. Some countries have put efforts to increase health awareness as part of pre-departure training program. At destination countries, health-awareness programs are also provided to migrants by governments, NGOs and international agencies. These features however focus only on HIV/AIDS/reproductive health awareness while other aspects of health awareness have not been paid much attention. The problems of health interventions for migrants are still hindered by the complexities of the situations, policies and stakeholders involvement (particularly conflict interests of people involved). Continued coordination and implementation between national, regional, and international health policy and planning are essential to put forward improved healthcare and services.

2. Background

Migration in the GMS has been growing rapidly in the last decades. It is estimated that about 2 million migrants moving around the GMS countries over the past few years 6. According to the Asian Migration Centre, as of 2007, about 1.8-3.3 million migrants moving around GMS countries. Thailand alone absorbs an estimated 1.5 million migrants from Cambodia, Laos, and Myanmar. In Laos, there are about 15,000 Vietnamese migrants and 80,000 Chinese migrants 7. As of 2004, there are about 150,000 - 200,000 Vietnamese migrants in Cambodia 8.

A number of migrants in Thailand particularly from Cambodia, Laos, and Myanmar are low-skilled labors. The three common professions that migrants most involved are – Agriculture (380,488), Construction (259,884), and Private Household (178,558) 9. Others include professions such as construction work and fisheries. A large number of female

7 Ministry of Labor and Social Welfares, Laos (as of 2006) and Asian Migration Center (as of 2004). There are also some migrants working in Myanmar; however the number has not been estimated.
8 Asian Migration Centre (As of 2004), cited Resource Book Migration in the Greater Mekong Subregion, page xii
9 This figure is based on number of work permits requests and issues by Office of Foreign Workers Administration, Department of Employment, Ministry of Labor, cited Labor Migration in Thailand, pp 31
migrants are involved in domestic work, restaurants and hotels, and sex industries. Vietnamese migrants in Cambodia and Laos are a mixture of low and medium-skilled labors. The skilled workers are involved in construction work, carpeting, business, and mechanics. Many female Vietnamese migrants work as nail dressers, sex workers, or small business holders. Many Chinese migrants in Laos work in agriculture, trade, and business.

Migration factors in the GMS are mainly based on economic reasons. A lot of migrants from these countries are from the rural areas. One of the major reasons for migration is to increase income through earning more from abroad. A lot of migrants are young, low-skilled, and low-educated. For instance, if combine the educational levels of male migrants from Cambodia, Laos, and Myanmar (age between 15-19 years old) in Thailand, about 50 percent of the migrants have never attended school, 30 percent finished high school, and only about 17 percent attended higher education. In countries like China and Vietnam, the high skilled migrants who can stay in competitive environment either remained in the countries or move to developed countries outside the GMS, while other lower skilled labors often migrate to neighboring countries in the GMS.

Low-skilled labor migrants tend to have low-profile living and involve in professions that are risky to their health and well-being such as living in substandard living places, involving in 3D jobs “dirty, dangerous, and difficult” and professions that are risky to their health and lives. These factors will continue to put them in a high risk position if supporting policies are inadequate or not available.

3. Methodology

The study is based on a combination of qualitative study and an extensive literature review of previous studies on Greater Mekong Subregion and several international agencies known in the subject area. Data collection includes field visits to several sites in Phnom Penh, Cambodia, Champasack and Vientiane, Laos. Information on migrants based in Thailand is also collected from government officials and agencies working on monitoring of migrant workers at destination countries particularly in Thailand.

Qualitative data was collected through approximately 20 one-on-one interviews with individual migrants and agencies who are involved in migration issues and 10 group interviews with migrants and their families. Information is collected from the migrants involves the following:

- Cambodian migrants working in fishing and garment factories in Thailand
- Vietnamese migrants working in agriculture, labor work and construction in Laos and Vietnamese migrants working in garment factories and labor work in Cambodia
- Lao migrants working in manufacturing and factory in Thailand

4. Stages of Migration and Health Environmental Situation and Problems

4.1 Before Migration

4.1.1 Health Related Quality of Life at Countries of Origin

The socio-economic situations of the GMS countries are one of the major factors determining the health concerns at origin and destination countries. In the GMS, a high rate of poverty and uneven development is one of the reasons migration is increasing. The determinant of poverty, education, and other socio-economic factors reflect that health prevalence lies in great differences between these components in the GMS.

In the GMS, Laos (133), Myanmar (130), and Cambodia (129) are among the three countries whose human development index is low, compared to the other three GMS countries Vietnam (109), China (85) and Thailand (74). This reflects the overall health related quality of lives of later three countries are generally better than the first three. For poor countries, public health problems are more associated with poor primary healthcare, poor access to health services, and poor quality of healthcare. Statistics show that incidence of poverty rate of these countries are high while the level of health access to sanitation are low (see Table 1). This suggests that these indicators play essential roles in health related quality of lives and prevalence at both origin and destination counties particularly when population mobility occur.

---

Table 1: GMS Core Health Indicators

<table>
<thead>
<tr>
<th>Core Health Indicators</th>
<th>Cambodia</th>
<th>China</th>
<th>Laos</th>
<th>Myanmar</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (in thousand)</td>
<td>14,071</td>
<td>1,323,345</td>
<td>5,924</td>
<td>50,519</td>
<td>64,233</td>
<td>84,238</td>
</tr>
<tr>
<td>Population living below poverty line (&lt;1% a day)</td>
<td>N/A</td>
<td>16.60</td>
<td>27.00</td>
<td>N/A</td>
<td>&lt;2</td>
<td>N/A</td>
</tr>
<tr>
<td>Life Expectancy at birth (Male)</td>
<td>51</td>
<td>71</td>
<td>59</td>
<td>56</td>
<td>67</td>
<td>69</td>
</tr>
<tr>
<td>Life Expectancy at birth (Female)</td>
<td>57</td>
<td>74</td>
<td>61</td>
<td>62</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>Adult literacy</td>
<td>73.60</td>
<td>90.90</td>
<td>68.70</td>
<td>89.90</td>
<td>92.60</td>
<td>90.30</td>
</tr>
<tr>
<td>Access to improved drinking water sources (%)</td>
<td>urban</td>
<td>64</td>
<td>93</td>
<td>79</td>
<td>80</td>
<td>98</td>
</tr>
<tr>
<td>Access to improved drinking water sources (%)</td>
<td>rural</td>
<td>35</td>
<td>67</td>
<td>43</td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>Access to improved sanitation (%) urban</td>
<td>53</td>
<td>69</td>
<td>67</td>
<td>88</td>
<td>98</td>
<td>92</td>
</tr>
<tr>
<td>Access to improved sanitation (%) rural</td>
<td>8</td>
<td>28</td>
<td>20</td>
<td>72</td>
<td>99</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: Adapted from WHO

Despite the general health indicators, the GMS are also facing common threats of communicable diseases. Statistics show that many GMS countries share a number of high prevalence of communicable diseases. Among these countries, Cambodia has the highest prevalence of HIV (1,468) (per 100,000 populations) as of 2005, followed by Thailand (1,144) and Myanmar (982) (see Table 2). The prevalence of tuberculosis has been decreasing steadily since 1999 (see Annex – Figure 1), and the incidence has declined slightly regionally from 1999. In addition, the incidence of tuberculosis in Thailand has been constant (Appendix 2). Among the GMS Countries, Cambodia has the highest prevalence of tuberculosis (702.9 per 100,000 population/year), followed by Laos (305.8 per 100,000 population/year) and Vietnam (175.2 per 100,000 population/year). High prevalence of these diseases is one of the main factors contributing to risky position when population mobility occurs.

Table 2: GMS Disease Prevalence Statistics (as of 2005)

<table>
<thead>
<tr>
<th>Core Health Indicators (per 100,000 population/year)</th>
<th>Cambodia</th>
<th>China</th>
<th>Laos</th>
<th>Myanmar</th>
<th>Thailand</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death due to HIV/AIDS</td>
<td>114</td>
<td>2</td>
<td>&lt;10</td>
<td>73</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>HIV prevalence among adults +15 years</td>
<td>1,468</td>
<td>62</td>
<td>103</td>
<td>982</td>
<td>1,144</td>
<td>421</td>
</tr>
<tr>
<td>Prevalence of tuberculosis</td>
<td>702.9</td>
<td>208</td>
<td>305.8</td>
<td>170.4</td>
<td>204</td>
<td>234.8</td>
</tr>
<tr>
<td>Incidence of tuberculosis</td>
<td>505.5</td>
<td>100.3</td>
<td>154.6</td>
<td>170.9</td>
<td>142.3</td>
<td>175.2</td>
</tr>
</tbody>
</table>

Source: Adapted from WHO

Many countries in the GMS also share the incidence of dengue fever. Population mobility both within the origin and destination countries plays an essential part on public health particularly when prevention and control under this movement has been slow.

4.1.2 Health Profiles Before Migration

There has been little record on health profiles of migrants in the GMS. Previous studies and records have been complicated because there is no system in place. Many out-going labors through legal channels are conducted through labor exporting companies and the Ministry of Labor and Social Welfares in the respective countries. In the GMS, Thailand and Vietnam have long experience involving out-going migrants. Nevertheless, information on health are not well monitored despite Thailand has done a number of surveys to keep records of health related issues among migrants in Thailand. Nevertheless, the health profiles contain health history of out-going migrants for many countries in the region are lacking.

Prior to departure, countries in the GMS use several kinds of health screening devices to detect out-going migrants’ conditions. For example, most countries require HIV and tuberculosis screening test. This screening test is claimed to help destination countries to avoid public health risk and conditions, and burden on the host country’s health service. At times, screening test is done according to the labor law and employment requirement at destination countries. In some cases, HIV test is required for out-going migrants. This particular test is applied in all countries in the GMS particularly if out-going migrants are sent through labor exporting companies and the requirements (compulsory testing) from many developed countries such as Singapore, Malaysia and so forth.

The implementation of pre-departure training on health in the GMS has not been standardized; some have implemented better than others. Often times, pre-departure trainings are conducted by a number of stakeholders involved. Problems involved health-related pre-departure trainings are hindered by lack of cooperation of private sectors particularly those labor exporting companies. These companies sometimes worried that migrants would claim for their rights if they know about what to expect. Labor export companies also claim pre-departure trainings should be done by themselves as they are worried that training conducted by different partners might meet the different requirements and standards of the employment at destination countries. This hinders the government and concerned stakeholders from following up on health training and enforcement particularly when these trainings are ignored by companies because they have to bare the additional costs.

14 Field Note in Cambodia, August 2007
15 Field Note in Cambodia, August 2007
4.2 During Migration

4.2.1 Health Problems

Health problems among GMS migrants during migration involve all aspects -- physical and mental, communicable and non-communicable diseases. In general, incidences over communicable diseases among migrants are more evident. One reason might be because communicable diseases are among the most detected conditions at pre-departure at origin countries and also during migration in destination countries. According to the study on Migrants’ health vulnerability to HIV/AIDS in Thailand, out of 800,000 tested migrants in Thailand, about 10,000 migrants are detected with health problems. Among those 600 migrants who are detected with HIV/AIDS are put on probation from work until treated. Among 6 diseases that are detected, TB accounts for 60 percent, while syphilis accounts for 33 percent. Studies on Labor Migration also documented that, as of 2004, tuberculosis was the highest disease prevalence among tested migrants (see Figure 1). Studies on Labor Migration in the GMS also documented that, as of 2004, tuberculosis was the highest disease prevalence among tested migrants, with about 60 percent (5,300 out of the 9,500) applicants found infected. One of the reasons for this is because migrants do not often receive treatment for these diseases nor their children receive vaccinations like other non-migrant populations.

![Figure 1: Result Health Exams of Migrants in Thailand (2004): Probation from Work until Treated](image)

Source: Office of Administration Commission on Irregular Immigrant Workers, Ministry of Labor and Social Welfare - as of Dec. 15, 2004

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16 Therese, Caouette, Sciotino, Rosalia, Guest, Phillip, and Feinstein Allan: 'Labor Migration in the Greater Mekong Subregion', pp 52
18 Raks Thai Foundation) Migrants’ Health and Vulnerability to HIV/AIDS in Thailand, pp 4
Additionally, study on Labor Migration in the GMS indicated that malaria is the main cause of death among migrants in Thailand, followed by mosquito-borne diseases such as dengue fever. This incidence is also found among plantation sites in Champasack, Laos where Vietnam migrants complained about exposing to health problems. Despite these emergent concerns on migrants’ health on communicable diseases, other significant health hazards include diseases related to malnutrition such as beriberi, skin and eye infections 19.

4.2.2 Factors Determining Health Problems

Risk factors determining health problems of migrants in the GMS varied, although many cases are found to be more common. Whether migration is documented or undocumented, factors contributing to health problems among migrants are enormous. During migration, health problems among migrants are associated with many conditions:

4.2.2.1 Substandard Living Conditions

The living conditions of migrants can be an essential factor creating risk for both their physical and mental health. In the GMS, there have been repetitive cases of migrants’ experience. Often times, the rooms they live in are small. Sometimes, the bathrooms are shared between men and women 20. For instance, several Lao migrants working in manufacturing business are reported to live in accommodations provided by many companies, where men and women shared the same bathrooms.

Some migrants in Thailand are reported to live in sleeping quarters with poor ventilation and hygienic facilities 21. Migrants who work in the farms are sometimes offered animal shelters to sleep over 22. These living conditions often put more migrants’ health at risk. In China, the incidence of infectious disease in areas with

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19 Therese, Caouette, Sciortino, Rosalia, Guest, Phillip, and Feinstein, Alan: Labor Migration in the Greater Mekong Subregion, pp 52
20 Note from Field study, Interview about Laotian Migrants, August 2007.
22 Note from Field study, Interview about Laotian Migrants, August 2007.
high density of migrants is higher than that of local population 23.

Regardless of their living conditions, migrants also found to expose to conditions of using unclean water. In Cambodia, several groups of migrants live on floating boats on the Mekong River. Living on the river means that these people depend on the consumption and uses of unclean river. In some areas, about 90 percent of people lived in such areas that have digesting problems resulting from unclean water 24. This incidence is, however, not found among high-skilled labors. Our interview in Cambodia with high skill labors indicated that they tend to use sanitized water instead of water directly from the river as they are more aware about their health. This reflects that those who are high-skilled have more choice the way they live compared to low-skilled labors.

4.2.2.2 Harsh Working Conditions

Working conditions also play an essential role in contributing to migrants’ health and well-being. The migrants, especially low-skilled labors often involved in the 3D jobs “dirty, dangerous, and difficult”25 and these factors put them at higher health risk. The jobs that low-skilled migrants involved often cause serious injuries accidents, and long-term health effects. In many cases, no compensation for accidents has been made by employers and migrants who face serious accidents have to return home when their health decline or they are not in the position to perform.

Health problems resulted from working conditions are associated with poor occupational health and safety policies and control. Migrants involved in many professions at times do not receive effective protection from their work. For instance, migrants involve in agriculture and farming business often work without safety protection from chemical products or exposure to pesticides. In Laos, plantations involve cutting grass, weeding, putting fertilizer, and planting of rubber is used without safety protection 26. In another case, workers have to work from either very low or high temperature.

24 Note from Field study, Interview about Vietnamese Migrants in Cambodia, August 2007.
26 Note from Field study, Interview about Laotian Migrants, August 2007.
Many Lao migrants involving in chicken manufacturing business have to work in a room temperature between 8–10 Celsius degree. This causes health problem to the workers since majority of them are from tropical climate. On the contrary, Vietnamese workers involving in smith business have to work in front of high temperature up to 1000–3000 Celsius degree with massive of industrial dusts in the workplace without effective safety protection.

The overall working conditions and place are also surrounded by stained metals and steels. Our interview with smith employees revealed that this business often offer jobs to young men at below 30 years of age. This is because these young people are still healthy and they can perform well in this harsh working condition. Cases of returned migrants often occur when they cannot stand the working situation.

27 Raks Thai Foundation: Migrants’ Health and Vulnerability to HIV/AIDS in Thailand, pp4
28 Note from Field study, Interview about Vietnamese Migrants, August 2007
4.2.2.3 Low Health Access

In the GMS, many migrants are moving to countries where healthcare are better than that in the home countries. Health accessibility is often low to migrants because accessibility is restricted. Migrants often choose to visit the pharmacies instead of going to hospitals even though they have insurances. In Thailand, for instance, legal migrants are eligible for health insurance according to the government’s 30 Baht Health Scheme 29. The workers must pay 5 percent of their salaries for social securities. Social securities often compensate up to 200,000 Baht for accident related on their jobs. In the first three month, when social security is not covered, they tend to rely on factory owners for health related supports. In many cases, factory owners are responsible for their illness during the first three months. There are difficulties in using this health scheme. There are still complaints over the 30 Baht policies among migrants. Some migrants feel that they are often discriminated and treated badly compared to other the local citizens. In many cases, the treatment is offered but with low quality. In some cases, migrants are fear of using the service as they are worried about having to pay fees that arise from invisible payment 30. In another case, they tend not to use the service if their employers cut their salaries during their absence from work. These often hinder them to access the healthcare even though they have insurances.

In Laos and Cambodia, the social security system has not been well-established. At times, migrants are offered access to private clinics available at their workplaces. In case of serious illness, migrants rely on local hospitals. Nevertheless, attending hospitals means that their salaries are deducted when they are absent from work. In Cambodia, for instance, 20 percent of all garment factories workers are Vietnamese and Muslim (Cambodian-Islamic), but none of these workers are members of the Free Trade 31. The problem with factory’s membership is their salary or allowances are deducted when they go to hospital. Many workers also contact the Free Trade because they experience occupational diseases 32. The trade union in Cambodia provides support to factory workers to claim for their rights or any problems occurred during their employment. Nevertheless, this participation rarely includes foreign workers because the information media is in Khmer and far for them to reach. Another reason is the lack of access to health information. In Cambodia, migrants tend to be excluded from the support because of language barriers.

30 Therese, Caouette, Sciortino, Rosalia, Guest, Phillip, and Feinstein Allan: ‘Labor Migration in the Greater Mekong Subregion’, pp 52
http://apmnn.anu.edu.au/regional_members/LaborMigration%20in%20GMS.pdf
31 Free Trade is an independent union involving in supporting workers’ rights
32 Note from Field Trip
4.2.2.4 Declines in Health Seeking Behaviors

Health seeking behavior of migrants can be restricted because of economic pressures. This is one of the reasons for them to delay seeking health services since they need to spend their time for earning money. In addition, their attitudes over health seeking behavior are also limited from the distrust of quality and the methods of services at destination countries. For instance, many Lao migrants in Thailand indicated that they prefer the treatment methods in Laos. They feel that they are not familiar with treatment in Thailand. For Vietnamese migrants both in Laos and Cambodia, they feel more secure to have their treatment at their home countries when they have serious illness. Healthcare service is often priced double compared to the price in Vietnam. The workers prefer to return to have treatment in Vietnam for severe health related problems. In some cases, they have operation in Laos but recheck their health back in Vietnam later on.

4. 3. Upon Returns

4. 3.1 Health Concerns upon Reintegration

Cases of early migrants return comprised of many reasons. Many return cases are associated to health problems. According to the health detection of the government discussed above, those who have serious conditions, for instance, third stage of syphilis or last stage of tuberculosis, often disallow migrants to continue working in destination countries. If the conditions are diagnosed early, return cases mean migrants have to pay back debt and fees to labor exporting companies. Often times, there are cases involved selling their property to settle debts. This means the money spend for healthcare for families will be used to settle debts and their unemployment.

5. Implications on Long-term Health Related Quality of Life

5.1 Investment on Health

According to Maltoni’s 2007 study on remittances by areas of investment, remittances of migrants are mainly used to repay debts and purchase daily consumption commodities including health compared to other investment. Investment on health accounts for 31 percent of household use from received remittances; however, investment on health means spending bills on their health problems rather than improve health quality. For poor migrants, remittances are used for housing and goods. For the poor and low-skilled labors, investment of remittances will have very little effect on future health related quality of life.

because money spent on health implies doctor's bills rather health improvement 34. According to the study of Maltoni, only about 3 percent of remittances are invested on education while little information regarding remittance investment on business development is found 35. This reflects that education, which is an essential factor on contributing to health awareness, is omitted from their daily expenses on consumption and debts. During our field study, interviewed migrants acknowledged their remittances are spent on health treatment rather than on prevention. In many cases, migrants often delay health seeking if the problem is found not to be serious. They tend to postpone health seeking or access health clinics to save money for daily consumption. This indicates that, for low skilled and income labors, daily expenses alone already make it difficult for them to survive while for those families with illness, only a small portion are spent on healthcare treatment at the hospitals.

5.2 Long-term Health Effects on Poverty

The long-term health problems of migrants can lead to more poverty. Previous studies found that many harsh working conditions lead to long-term health effects including occupational diseases. These effects are accumulated and expanded the complexities to situation of families especially when families depend on one migrant only.

Case study 1: Health Impacts on Poverty of a Vietnamese Migrant Working in Cambodia

A Vietnamese worker migrated to Cambodia several years ago to work as a labor. His work involves carrying heavy things at long hours everyday. After several years of working, he became ill and cannot walk because of his back problems and bone diseases. This leads to his families having to sell everything they own to survive. The families have to move to a small rental room of about 8 square meters which accommodates 5 family members with one who is pregnant. The families are now also in debt because their young son is infected with HIV. Information about healthcare often involves fees and payment and so they tend to avoid seeking the information from local authorities.

5.3 Recommendations

Increasing support on health among migrants is necessary for government to look at long-term effects and health of migrants and development upon their return. Solving this problem requires regional governments to deal with a combination of policies attitudes to healthcare and services on long-term development of migrants and changing demography

in the GMS over a period of time. Recommendations are provided specifically to problems found in particular countries in the GMS in regards to promoting health welfares among low-skilled labor migrants:

5.3.1 Cambodia

- Strengthen enforcement of private sectors’ support on pre-departure training particularly on health awareness including other communicable and non-communicable diseases other than HIV/AIDS.
- Intensify in-country monitoring system to access information about Cambodian migrants abroad while also promoting health information access through existing NGOs networks (such as CARAM Asia).
- Promote means for migrants to increase their saving and remittances on education and business development that will contribute to their long-term development.
- Promote health awareness programme among potential migrants before they leave the country. This includes illegal migrants access to health information at destination countries.

5.3.2 Lao PDR

- Institutionalize and expand Social Security System in areas where there is high number of international migrants.
- Promote and enforce pre-departure training particularly on health awareness including other communicable and non-communicable diseases other than HIV/AIDS including strengthening health awareness programme among areas with high level of migration using illegal channels.
- Strengthen income generating programs at local levels to provide means and support for return migrants who have health problems.

5.3.3 Thailand

- Enforce occupational health and safety in areas with high numbers of low-skilled labors particularly from Laos and Cambodia.
- Strengthen cooperation with neighboring countries to find means to promote health awareness and information access for low-skilled labor migrants through existing networks.
6. Conclusion

Health impacts among migrants are considered enormous. Based on this study, migrants’ health conditions are often associated with their long-term previous health conditions. Statistics indicated that incidences of high prevalence among migrants are those correlated with high prevalence at their origin countries. Nevertheless, in many cases, health impacts also involve in their long-term involvement in their harsh working careers and other conditions discussed above.

Health impacts of migrants are influenced by all stages of their migration process – pre-departure, during migration and upon return. At pre-departure, the information they receive related to their healthcare awareness are insufficient. During migration, the conditions often contribute to more severe health problems particularly incidence of infected communicable diseases. Upon return, no interventions involving health support for return migrants were given in their home countries.

Low-skilled labors migrants are among the most vulnerable groups. They tend to be excluded from health information channels and accessibility because of their low education, economic pressure, and lack of choices. Policies related to migration in the region have not paid much attention to the overall health problems of migrants. At the country of origin, pre-departure training and orientation practices are still hindered by many obstacles – lack of funding, conflict interest of stakeholders who get involved, and lack of cooperation from private sectors. At destination, efforts to promote health awareness have been implemented but difficult for many reasons -- difficult accessibility to migrants, discrimination, and lack of attention.

Solving these problems requires on-going cooperation, tacking existing problems and corruption as well as building on attitudes to supporting migrants’ health and welfares. GMS countries face an urgent need to consider health policies that are not effective in managing the increased of social problems resulting from the increased flows of migration into the region. In particular, not only HIV and reproductive health should be continued to be promoted but other health concerns, such as tuberculosis, malaria and other diseases that are highly detected among migrants, should be advocated and addressed in the future. In response to this, mechanisms at national as well as regional levels should be promoted in parallel to improve its administration of migration and health policies to protect migrants abroad and international workers in the country.
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