"ESCAPE FROM THE BEAR AND RUN INTO THE TIGER"*

The impact of violence and fear on migrants' reproductive health

BY THERESE CAOUETTE

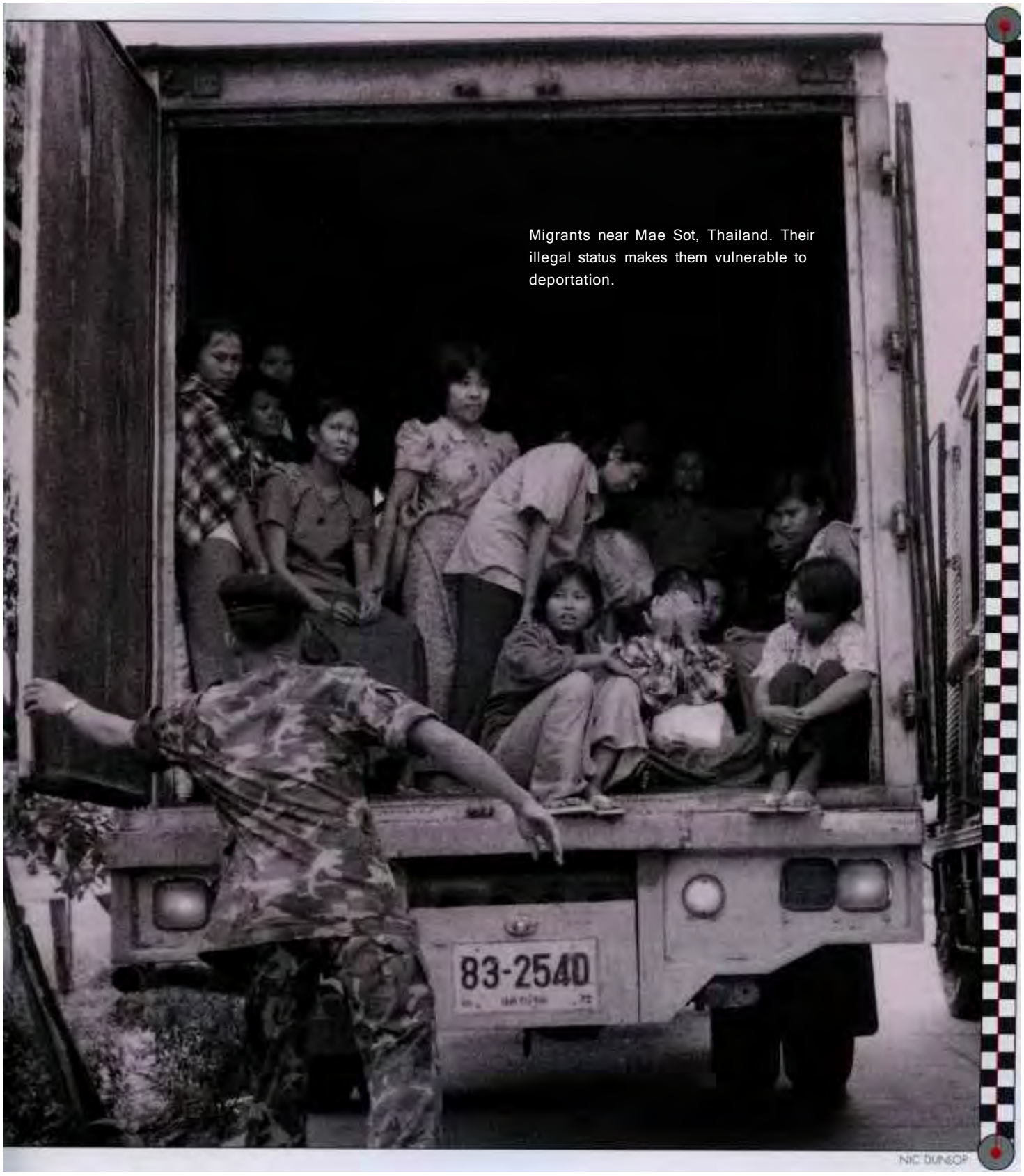
The Burmese soldiers would come to the village and force men and women to carry their ammunition that was very heavy. They would beat anyone who was slow and could not keep up. They treated women very badly and in the night they would rape us. They caught seven women from our village. They raped them all and one girl they kept for three days. Two of my nieces were among them. After that I left with my nieces and others from my village.

Shan woman, age 22, construction worker in Chiangmai

I tried to help some people out of the Thai police station. I went there and paid 13,000 bahtfor the release of two people. The people there asked me to help two women, a mother and her daughter whom the police and senior prisoners were raping all the time. The daughter was only about 17 or 18 years old and very beautiful. Before I could help, they both hung themselves. People said there were four other girls in police custody in a similar situation. It happens everyday.

Mon man, age 23, laborer in Mahachai

* A Shan Proverb



Migrants near Mae Sot, Thailand. Their illegal status makes them vulnerable to deportation.

INTRODUCTION

The massive influx of migrants from Burma into Thailand is one of the largest migrant populations in Asia. Over one million migrants from Burma are currently residing in Thailand. An ethnically diverse group coming from all over Burma and speaking many different languages, these migrants often lack a common language even among themselves. What they do share are encounters of fear and violence, that affect most facets of their lives.

During 1998, an *Assessment of Reproductive and Sexual Health Perspectives, Concerns and Realities of Migrant Workers from Burma in Thailand* was conducted under the guidance of Mahidol University's Institute of Population and Social Research (IPSR). The recently published results of the study reveal that a fear of violence and a preoccupation with staying safe determines almost every aspect of the migrants' lives, including their health care options and decisions.

The study highlights the extremely limited health services that exist in Burma as well as the problems encountered by migrants in Thailand such as the ready availability of medicines without access to health services or education. Consequently, people from Burma suffer from easily treatable conditions, presenting a health care crisis on both sides of the border. Most migrants from Burma in Thailand reside illegally and are generally unable to communicate in Thai. They are often in situations which leave them vulnerable to violence and abuse by employers, authorities and even each other. These experiences, coupled with fears of violence and exploitation, create a vacuum in which the migrants have few or no options for health services. This reality is further compounded by cultural mores and the lack of basic and reproductive health education, which lead to high maternal mortality and morbidity rates, unwanted pregnancies, unsafe abortions and sexually transmitted diseases (including HIV/ AIDS).

GOVERNMENT POLICIES

In order to provide a context for analyzing the results of the study, it is important to examine the way in which official policies and governance in Burma and Thailand directly impact migration flows and the reproductive health status of the people from Burma. Recognition of these policies and conditions under which people live is critical to understanding why and how people migrate from Burma.

... a preoccupation with staying safe determines almost every aspect of the migrants' lives ...

Migration in Burma

The one-party political system has been in place in Burma for nearly forty years repressing all opposition to its power and policies. The ethnic minority populations in particular have faced extensive violence and repression as a result of civil war and a nationalistic political system, which has not been open to cultural diversity, but rather has imposed a national language, culture and religion. In addition, the government of Burma has harassed, arrested and even killed many of those who in any way challenge this political system. The policies and violence that has suppressed the people of Burma has led to the displacement of millions both internally and across the borders into neighboring countries.

In 1987, the United Nations designated Burma as a Least Developed Country. The government of Burma's policy, known as the Burmese Way to Socialism, promoted isolation that sealed the country off from the outside world and policies that further impoverished its citizens over decades. In 1988, the government of Burma introduced its "Open Door Trade" policy following its crackdown on the pro-democracy uprisings and subsequent international sanctions, in an effort to secure foreign exchange, cross-border trade and foreign investment. These policies led to officially opening border crossings and expanding infrastructure to support trade, particularly with China and Thailand. This in turn led to migration. However, the government of Burma still maintains restrictive laws on movement that are often enforced solely at the discretion of local officials, leaving traders and migrants increasingly vulnerable to arrest and violence as they seek covert routes to cross the border.

In promoting its "Open Door Trade" policies, the government of Burma has sold concessions for timber, rubies, oil and fishing. These concessions have also led to mass migration and relocation in order to make room for such ventures or as people search for work with these businesses.

Reproductive Health Policies and Realities in Burma

Burma has some of the highest rates of maternal morbidity and mortality in the world. In 1997, the World Health Organization (WHO) and UNICEF estimate that the maternal mortality rate in Burma was as high as 500-580 per 100,000 live births. With abortion illegal in the country and contraceptives only legal since 1991, the Ministry of Health and UNFPA estimated in 1999 that one-third to one-half of maternal deaths have been the direct result of unsafe abortions. Given these high rates of maternal mortality, safe motherhood is a critical issue throughout the country with basic health services available to 209 of the 320 townships nation wide. In 1994, the Ministry of Health and UNFPA found that even in townships with basic health services only 48% of the population was reached. Since 1991, the government began a "birth spacing" program that has expanded in 1999 to 117 of the 320 townships. This highlights the unmet need for safe and effective contraceptives in Burma and recognition of the constraints that lie not only in the limited availability of health services, especially reproductive health commodities, services and information, but also in their quality and delivery.

To date, reproductive health policies and programs have not taken into consideration the large-scale migration occurring throughout the country. This perpetuates the risks of maternal mortality and morbidity as well as the general health of the larger population of Burma and its neighbors.

Thai Government's Policies on Undocumented Migration from Burma

Thai government policies related to undocumented migration from Burma have changed markedly over the last three decades as a result of national security measures and improved Thai-Burma relations. During the 1970s and 1980s, most of the migrants settled in the Thai border provinces. Following the government of Burma's suppression and opening of the country in 1988, hundreds of thousands of people from Burma fled across the borders and in the years that followed, spread throughout the whole country of Thailand. Given the demands for unskilled labor, the Thai government enacted four Cabinet Resolutions (between 1992-1999) to provide a more flexible immigrant labor policy. These resolutions basically allowed employers to legally register migrants for specific jobs according to the type of industry and the province. However, implementation of these resolutions has been problematic with the majority of migrants remaining undocumented and hidden from government's umbrella.

Percentage Distribution of Participants According to Ethnicity

Ethnicity	Ranong	Chiangmai
Dewai	42.8	0.0
Burmese	41.1	0.7
Shan	0. 2	96.3
Mon	12.0	0.0
Karen	1.7	0.7
Kachin	0.2	0.7
Others	1.9	1.5
Total: Percent	100.0	100.0
Number	418	409

Migrants from Burma and Access to Health Care in Thailand

Due to their 'illegal' status, the majority of migrants from Burma in Thailand are often unable to access government services and live in fear of harassment and arrest. In response to the growing presence of undocumented migrants from Burma, the Thai Ministry of Public Health (MOPH) has sought to understand the health realities and provide basic health services to migrant populations. MOPH data has found that among migrants from Burma in Thailand malaria was the leading cause of death, followed by accidents, especially from workplace injuries and motorcycles. Malaria, along with acute diarrhea and tuberculosis, are on the rise among migrant workers and have become once again a serious health threat to Thai citizens. In 1996, when the number of provinces allowed to employ illegal aliens was expanded from nine to 43, some criticized the Thai government for not adequately adopting public health measures to cope with the burgeoning

Migrant workers from Burma displaying temporary identification cards issued by the Thai government. Most migrants reside in the country without such documentation.

migrant population. The Thai government has since begun to initiate new programs in some provinces that provide family planning services and promote disease prevention and environmental sanitation. Even within areas where these initiatives have begun, problems still exist with regards to implementation, and health officials at various levels do not fully embrace these new policies.

Given the sensitivities in acknowledging displaced and undocumented populations and the abusive realities they often encounter (both in Burma and Thailand), migrants tend to be isolated and excluded from the discourse and initiatives of the general public, governments and international agencies. As a result, contact with these populations is extremely limited, making it difficult to provide health information, commodities and services, especially regarding reproductive and sexual health.

STUDY SITES AND PARTICIPANTS

Chiangmai Province is a northern Thai province that borders Karenni and Shan States of Burma. Agriculture is the predominant industry in Chiangmai Province, whereas in Chiangmai city, construction, small factories and service sector jobs prevail due largely to the extensive tourist industry. The majority of migrants from Burma working in the Chiangmai are of Shan ethnicity. The Shan spoken language and many aspects of its culture have some similarities to that of northern Thailand, which also has an ethnic Shan population. As a result, it has been easier for Shan migrants to communicate and find their way into Thailand compared to other migrants from Burma.

This study focused on those working in the areas surrounding Chiangmai city. The majority of the participants were construction workers who typically lived on the site where they work. The makeshift housing was generally constructed of tin, had no ceiling or windows, was hot, overcrowded and offered little privacy. People interviewed in the study consistently complained about a lack of clean water, insufficient or filthy toilets and generally unsanitary conditions. Factory workers in Chiangmai who participated in the study also lived at their work sites in housing similar to, although somewhat cleaner than, that of the construction workers. They usually had access to free water and electricity.

Ranong Province borders the Tennasarim Division of southern Burma and is situated opposite Kawthaung, Burma's southern-most town. Most migrants from Burma residing in Ranong enter Thailand from Kawthaung. The majority of partic-

ipants in Ranong were Burmese of Tavoyan decent, but also included significant numbers of Mon, Karen and Arakanese ethnic populations. In Ranong, fishing or fishery-related jobs and agriculture plantations (mostly for rubber) [are] the dominant industries.

In Ranong, agricultural workers commonly live together in row houses in the middle of the plantation. Although few workers interviewed in this study were provided work permits, the plantation owners often gave migrants a verbal guarantee of safety on the condition that they remain on the compound. Those migrants working in factories in the fishing industry generally lived in the port area several miles from the center of town. Overcrowding, filth and an ever-present smell of fish [are] common features of the port area. For example, one of the homes observed housed 35 people. The situation would have been untenable except they worked in shifts and not everyone was home at the same time.

Mahachai, a port city of Samut Sakorn Province, is an industrial area just outside of Bangkok. Mainly factories, predominantly fish processing plants, are located here. Communities of migrants from Burma in Mahachai live in extremely crowded housing, so much so that one could easily mistake Mahachai for a border town rather than an industrial city situated near Bangkok. According to some Thai officials, Mahachai has been home to the largest community of migrants from Burma on the Bangkok periphery. A diverse spectrum of ethnic groups comprises the migrant population from Burma in Mahachai, including Burmese, Mon, Karen, Rakhine, Pa-O and Shan.

Those employed at the larger factories in Mahachai typically rent rooms together (as many as twenty persons might stay in one room, dividing the living space with cloth). Migrants working in the smaller factories often live on the work site in rooms or shacks constructed of tin and wood.

At all three sites, the vast majority of migrants interviewed were receiving far below Thailand's minimum wage. Men received significantly higher wages than women in similar jobs with children who receiving the lowest renumeration. Wages ranged from 70 baht to 160 baht [approximately US$2.00 to $4.50] per day. From these wages deductions were often taken by the employers for bribes to avoid arrest, water and electricity, and in some cases even for rent. Most people interviewed, and almost all females, reported being afraid of arrest and violence, only emerging from their living quarters to work or when absolutely necessary.

The Three Research Sites and Major Border Cities along Thai-Burma Border

Percentage of Participants Who Experienced Economic Violence and Abuse

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
% not paid for work	25%	25%	25%	39%	68%	53%
(N)	(51)	(50)	(101)	(84)	(129)	(213)
% abused by employer	30%	19%	25%	51%	68%	59%
% trafficked	2%	3%	3%	8%	2%	5%
(N)	(5)	(6)	(11)	(18)	(3)	(21)
% trafficked by employer	0%	0%	0%	77%	67%	76%
% trafficked by close friends	40%	50%	45%	11%	0%	9%
Number	208	203	411	216	189	404

Percentage of Participants Who Experienced Forced Labor and Relocation in Burma

	Ranong			Chiangmai		
	Women	Men	Total	Women	Men	Total
Forced as Porter	30%	19%	25%	51%	68%	59%
Forced Labor	75%	60%	67%	77%	83%	80%
Forced Relocation	18%	15%	16%	44%	51%	47%
Total Number	210	208	418	218	191	409

In Ranong and Chiangmai, the majority of migrants enter Thailand by crossing the porous border or with a day pass at the border checkpoint. However, in Mahachai, most of the participants in the study described being brought into Thailand by agents who required fees for providing transport and locating employment, leaving them in debt for several months – even up to a year – upon their arrival. In areas with diverse ethnic composition existed, the lack of common language and culture often allowed employers and agents to cultivate fear and mistrust among the various groups.

EXTENT OF VIOLENCE

The migrants who participated in this study reported numerous accounts of violence, both in Burma and Thailand. The findings show that violence and the fear of violence directly limited the ability of the participants to address health issues and seek treatment for health-related problems while they were in Burma and after their arrival in Thailand.

In Burma, a wide range of State abuses was reported while some encounters of violence by opposition or minority factions were also noted. These included: war and/or political repression; forced relocation; forced conscription of porters, soldiers and laborers; rape taxation; and other forms of harassment. These abuses were the predominant reasons given for leaving Burma as well as for staying on in Thailand, even when migrants reported not profiting economically from their labor.

My husband was an assistant headman in our village and he served in the Peoples' militia. He had to be

afraid of different groups. He had to collect rice and money when the insurgents asked for it and if the Burmese soldiers suspected him they would punish us. Some time in the summer of last year, the people of our village were beaten and forced to move to another town by Burmese soldiers. It happened because the insurgents borrowed the large cooking pots from the temple and the monks could do nothing but lend it to them. Then the Burmese soldiers attacked and overran their base. They found the cover of a large cooking pan with our village's initials on it. They came and beat the villagers and took all the money and gold that was kept with the Abbott at the temple. They even beat the Abbott and forced him to disrobe. They forced everyone to leave in the night.

Shan woman, age 33,
construction worker in Chiangmai

Almost one half of the participants in Chiangmai, who were primarily Shan, had been subjected to forced relocations and 60% of them had endured forced conscription as porters. The proportion of participants conscripted as forced labor was high at both the Ranong (67%) and Chiangmai (80%) sites. The fear of rape and arrest by the military or government personnel was also a critical factor in the decision to leave Burma for the migrants from Shan State. Arbitrary taxation and fixed prices for food, often considerably below market value, forced many people into poverty throughout Burma. These factors were cited as the predominant reasons for leaving the country and staying on in Thailand, even though it was difficult for the migrants to sustain a livelihood there.

Fear and violence followed the migrants into Thailand. Study participants consistently reported encountering abuses, primarily as a result of their illegal status. Nearly half of all the participants (45%) had been arrested at least once by Thai police or soldiers, who often extorted money from them for their release or detained and deported them to the border.

Over one-third of the migrants (38%) reported being cheated or abused by their employers or at the workplace, with no recourse except to quit and seek a new job.

Fear and violence followed the migrants into Thailand, ... primarily as a result of their illegal status.

When I first arrived in Thailand I worked in a pineapple-canning factory. They paid so low and the work was so hard I decided to leave. But then I got arrested. After I was released I was told about a job in the shrimp market in Mahachai. Since I have come here I have had to change my job three times. I moved twice because I was arrested and once because I did trot like the way the owner treated me.

Burmese woman, age 37,
informal health provider in Mahachai

In addition, abuses by employers or at the workplace also involved collaboration with agents and traffickers; withholding or refusing to pay salaries; physical and sexual abuse; and lack of general concern for the safety and health of the migrants employed.

We worked for six months without receiving our pay. One day we finally asked for our pay. The employers told us if we wanted their money, we would have to take their guns as well. We were so frightened we ran away.

Tavoyan man, age 18, farm worker in Ranong

Sexual violence and other abuses in the community were also reported, predominantly by female participants. Since single girls and women were considered more vulnerable to discrimination and violence, they often married early or reported having married for protection.

The boss and his wife were kind, but the wife's brother used to visit them when the university was closed. He always tried to harass me physically. He pretended that he was just kidding by touching my private parts. I was afraid of him so I asked the Burmese caretaker to marry me. He agreed so now there is no problem.

Mon woman, age 22, farm worker in Ranong

Migrants reported high incidences of domestic violence in Thailand. One third of the migrants reported other forms of violence within the migrant community that directly affected their safety and security, such as fights, having their possessions confiscated or stolen, or being coerced or cheated.

IMPACT OF VIOLENCE ON HEALTH

Serious health problems among migrants from Burma in this study included malaria, workplace injuries, diarrhea, skin rashes and depression. The main factors determining migrants' decisions to seek health care (or not to) were their illegal status, financial savings and ability to communicate in Thai language.

We have no identification cards to go to the hospital and we don't speak Thai very well. We have to buy medicine from the drug stores and treat ourselves, and sometimes it gets worse. I have seen people get so sick they have to go to the hospital. They have to hire other people to accompany them, pay for transportation and expensive hospital fees. Every one tries to buy medicine to take care of themselves because it costs so much money to go to the hospital.

Shan man, age 34,
construction worker in Chiangmai

People without an ID card die. A girl who lived by the stream died from excessive bleeding. One cannot rely on the business owner. If you have no money or ID, you just die.

Mon woman, age 16, farm worker in Ranong

The majority of migrants first sought to address their health care needs by purchasing drugs or seeking traditional caregivers or healing methods. Many migrants explained that the general trend in their community was to avoid seeking health services until one's health deteriorated and one faced a life-threatening situation. The most common causes of death reported in this study were maternal mortality, malaria and work place injuries.

IMPACT OF VIOLENCE ON REPRODUCTIVE HEALTH

Limited information and inability to openly discuss sexuality and reproductive health issues prevailed across all three sites, intensifying the dilemma of seeking medical care. The extent of information and discussion on these topics varied according to gender and level of education. Male participants were more readily able to discuss these issues among themselves than were women. The participants who had received higher levels of formal education (largely Burmese from central Burma) had greater access to information on sexuality and reproductive health. The majority of female participants did not have this access and possessed little to no knowledge of such issues.

The vast majority of survey participants (90%) considered complications arising from childbirth delivery to be a major health problem. This was especially true among participants in Chiangmai. The majority of births reported among Ranong (and Mahachai participants), both in Burma and Thailand, took place at home, though more women went to hospitals to deliver in Thailand than they had in Burma.

The woman next door to me at the construction site was pregnant. She had no money and dared not go to the hospital. With the help of her husband they tried to deliver the baby in their room. But there were complications. It was nearly midnight and the husband tried to go to get help. When he came back his wife was almost unconscious. She delivered the baby in the car on the way, but she died before reaching the hospital. It was a baby girl and was adopted by one of the nurses at the hospital with the father's consent.

Shan woman, age 40,
construction worker in Chiangmai

Participants at all three sites reported little or no knowledge of or access to contraceptives while in Burma, [but an] increased use in Thailand. Oral and injectable contraceptives were the most commonly used form of birth control. The majority of contraceptive users purchased them from mobile markets or over-the-counter drug stores, while one third of the participants obtained their contraceptives from a medical clinic or hospital. All the participants were interested in obtaining more information on specific types of contraceptive methods and their side effects, particularly oral and injectable contraceptives.

I got an injection in my womb and they said it would prevent pregnancy. I did this four times, but it didn't work. I got pregnant again. My sister thinks maybe the medicine had expired.

Shan woman, age 35,
construction worker in Chiangmai

My wife asked *someone to buy pills for her. There are also injections but because we do not have identification cards and do not speak the language well, we are afraid to go.*

Shan man, age 29,
construction worker in Chiangmai

Among participants who reported having an unwanted pregnancy, 17% attempted abortions, though only 45% were successful. Reasons given for seeking abortions were typically that the women were not yet married, had too many children or were not in a secure political or financial situation to raise children. Women at all the sites reported serious side effects from abortions.

I first tried to induce an abortion with an injection. But after five days I had no menstruation. So, I paid to go to a midwife. She used an iron rod to abort. I was afraid so I returned home and instead asked my husband to massage and step on my stomach. I also bought medicines that are very hot. But, I still did not abort.

Tavoyan woman, age 42, sawmill worker in Ranong

Sixteen percent of the women and nine percent of the men believed their partners currently had other sexual partners. In addition, changes in sexual attitudes were found, particularly among the women, as a result of exposure to urban life, and migration out of tight social networks. Still, different sexual norms were evident. Strong values of virginity associated with girls and women; loss of virginity for those not yet married often resulted in serious consequences. Boys and men, on the other hand, were considered, by their nature, to have a greater sexual drive and to be more sexually active prior to marriage. Commercial sex patronage by men was described as a common social event. Social norms were supportive of single men visiting sex workers, but it was less socially accepted for married men.

The majority of participants had heard of condoms (91%), however, only 14% had ever used them. Men had more experience with condoms than women. Condoms generally represented mistrust and promiscuity, while not using a condom symbolized trust and loyalty to one's partner. Many women reacted negatively to condoms while men often did as well, but to a lesser extent. Although many had knowledge of condoms for protecting against diseases, such as AIDS, they expressed a lack of interest in using them.

I am too embarrassed to talk about condoms to my husband. I have no idea really. It doesn't concern me, so I don't even think about it. My husband and I don't

Percentage Distribution of Participants' Perceptions of Problems During and After Childbirth Delivery in Thailand

	Ranong	Chiangmai	Both Sites
Perception:			
Not serious	8	8	8
Somewhat serious	20	41	31
Serious	27	21	24
Very serious	38	28	33
Don't know	7	2	4
Total: Percent	100	100	100
Number	411	402	813
Place of Delivery:			
Hospital	34	94	63
Clinic	16	0	8
Home with TBA*	46	6	27
Home without TBA	2	0	1
Other	2	0	1
Total: Percent	100	100	100
Number	88	82	170
Place of Post-Natal Care:			
Hospital	36	66	50
Clinic	24	7	16
Traditional healer	8	25	16
At home	30	0	16
Other	2	2	2
Total: Percent	100	100	100
Number	67	56	123

"Traditional Birth Attendant
**Among those who had children born in Thailand.
***Among those seeking post-natal care.

need condoms in our relationship. Men use them only when they go fooling around.

Tavoyan woman, age 33, sawmill worker in Ranong

Almost all of the participants had heard of AIDS. Only 60% of the participants, however, were able to correctly answer questions about HIV/AIDS transmission routes. There was an overall lack of understanding about the differences between HIV and AIDS among all the participants. No one knew of the asymptomatic nature of HIV infection, and it was commonly believed that a healthy-looking individual could not possibly be infected with HIV/AIDS. Most participants felt that one should avoid all contact with individuals who manifested symptoms associated with AIDS. The discussion of AIDS conjured up fear and stigma for most of the study's migrants, however, only a few perceived themselves at risk of becoming HIV positive. The findings strongly suggest that participants perceived AIDS as a disease confined to a risk groups (primarily sex workers), rather than to a sexual behavior. This perceived association fueled fear and discrimination towards sex workers, an already highly stigmatized group.

CONCLUSION AND RECOMMENDATIONS

Migration from Burma is rooted in the country's political and economic problems. Human rights violations and anti-democracy crackdowns perpetrated by the government have not abated. Without addressing these realities directly with government officials, mass migration from Burma into Thailand will continue. Efforts by Thailand alone, such as deportation or repatriation, will not solve this problem. The Thai government must work with the international community, as well as directly with the Burmese government to address the root causes of migration flows from Burma. This can be done at the multilateral level with members of the Association for Southeast Asian Nations (ASEAN) and the bilateral level, through such mechanisms as the Bangkok Declaration on Irregular Migration.

The findings of this study suggest that changes in approaches of Thai domestic policy regarding migrant workers and their social status are required to formulate more humane and effective management of the problems. Policies on migrant workers in Thailand must be developed on both the national and provincial levels, with a framework for implementation that includes input and responsibilities from officials at both levels. Health care policy specifically focused on migrant populations is another important consideration necessary to improve the quality of life and the well-being of migrants as well as the larger community.

Migration from Burma is rooted in the country's political and economic problems.

Various groups of migrants, such as children, trafficked persons and asylum seekers facing human rights violations should be protected. Developing practices to protect migrants from these violations and help them seek redress is desperately needed. Active negotiation to develop and implement a repatriation policy to combat the high number of migrants in Thailand could reduce the number of migrants, but indirectly increase their vulnerabilities to abuse. Therefore, until systems for protection and redress are in place, repatriation will not be a viable option.

The findings of this study were presented for discussion and collaborative recommendations to a wide range of provincial and national government departments, employers and non-governmental organizations in Thailand. The focus of these forums was to provide basic health information and services to migrants, work with employers to improve working and living environments and register migrants and their families to work and reside legally in Thailand. The report concludes with a set of recommendations that are based on the findings of this study and the outcomes of these forums.

Therese Caouette was one of the principle investigators of this research project and has worked with migration issues in Asia since 1982. This article summarized the study report: Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand, *published in 2000 by the Institute for Population and Social Research (IPSR), ofMahidol University and co-authored by Therese Caouette, Kritaya Archavanitkul and Hnin Hnin Pyne. It is available in Thai and English from IPSR, Mahidol University at Salaya, Puttamonthom 4 Road, Nakkonprothom 73710, Thailand.*