

A Case Study of the Thai-Burma Border:
Migrants, the Sex Industry, and HIV/AIDS

June 2010

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Today's real borders are not between nations, but between powerful and powerless, free and fettered, privileged and humiliated. Today, no walls can separate humanitarian or human rights crises in one part of the world from national security crises in another.
(Kofi Annan)

Political tension found between Thailand and Burma stems from a long-standing relationship of distrust between the two countries that begins as early as the 1700's, when Burma invaded Thailand. The tension has manifested itself through the years in school curricula, the media, public policies, and other means, thus generating harmful stigmas and stereotypes. Presently, this tension is being exacerbated by the waves of migrants who are crossing over from Burma into Thailand. This influx of migrants, caused by policies and actions taken by the Burmese government, and the subsequent HIV crisis that is ensuing within Thailand, is likely to be a cause of conflict between Thailand and Burma today.

It is necessary to note that a percentage of migrants from Burma in Thailand are actually of an ethnic minority, but because of difficulty in obtaining solid research in these specific geographical areas as well as on this group of transient people overall, the migrants that have relocated to Thailand are often clumped together and labeled simply as Burmese (*Freedom House*). This case study will acknowledge that women, who cross the northern Thai border, are, besides the ethnic Burmese, often of the Shan, Karen, and Karenni ethnic groups. Because of the vast amount of research labeling people solely as Burmese and the limited amount of research that focuses on these specific groups, this case study will represent both ethnic Burmese women and the other ethnic groups under the label of ethnic Burmese. Despite this author's desire to discuss solely ethnic

minorities, a lack of research available limits any potential depth into one ethnic group. This lack of research exemplifies the voicelessness of, and the lack of international concern towards, the people focused on in this case study. At the present time, a report focused solely on them would be impossible.

There is a need to differentiate the ethnic groups from the ethnic Burmese because of historical differences. Both groups originally inhabited the lands in which they now reside, but the British government incorporated the ethnic groups into the originally all-Burmese state against their will. Therefore, beginning as early as 1948 in the aftermath of Burmese independence from the British colonization, tension among the Burmese government, Burmese people, and ethnic groups flared when the ethnic groups failed to receive the autonomy and/or independence that they sought and had sought since the British occupation (Barron 15). Again, by not acknowledging historical differences, the assertion of an ethnic minority identity is denied.

Not only is there tension between Thailand and Burma, there is also a climate of political turmoil within Burma, which has led to a mass migration of Burmese people. In efforts to maintain control, the ruling military junta has utilized various policies that have led to the flow of people into Thailand. One such policy has been the Four Cuts Policy:

The Four Cuts Policy ... aimed to undermine support for the armed opposition groups by cutting their access to supplies, information, recruits and food. To cut these networks the Burmese army targeted the civilian population. This led to increased militarization, forced displaced, human rights abuses and

oppression of Burmese villagers. The Burmese army is still implementing the four cuts policy in eastern Burma today. (Say)

As a result, “A 2004 report by the Burma Border Consortium found that since 1996, over 2,500 villages were destroyed or forcibly relocated, displacing over 600,000” (“Chronic Emergency: Health and Human Rights in Eastern Burma” 20). This policy is an example of the ruthless measures the Burmese government has been and remains willing to take in order to maintain control over its population.

The tension within Burma has contributed to the present-day exodus of people into Thailand. The numbers of the first wave of official migrants are difficult to track, but there are reports of displaced peoples from as early as 1975 (Barron 16, 35). As of 2004, there was an estimated population of 910,000 Burmese migrants who had registered for work permits within Thailand just within that year (“Migrants Health and Vulnerability to HIV/AIDS in Thailand” 12). Additionally, to add to the complexity of the situation, by 2004, an estimated 154,000 refugees have now settled in the eleven different refugee camps just inside the Thai-Burma border (Barron 16). There are also internally displaced people within Burma, others have fled to China, Bangladesh, India, and Malaysia, and others have been relocated abroad to a variety of countries that accept Burmese asylum seekers. These numbers are unknown. The mass exodus from Burma makes a clear statement about the conditions within the country.

As a result of having to flee their country, facing uncertain living conditions, an unstable political situation, and high mobility, migrants face situations of high health vulnerability. According to the definition, not all members of society are vulnerable in the same way; health vulnerability is dependent upon “those features of a society, social

or economic institution or process that makes it more or less likely that excess morbidity and mortality associated with disease will have negative impacts” (Barnett and Whiteside 166). More simply stated, “The more socially and economically marginalized a population, the greater its vulnerability to infection” (Altman 205). The social and economic conditions that the Burmese people and the varied ethnic groups face are often outside their control, limiting their potential choices and increasing their health vulnerability. Therefore, not only are migrants highly vulnerable to disease, they are also victims of structural violence, living in a world of limited choices (Farmer 279-80).

There are a variety of factors that determine health vulnerability; these are encompassed within John Burton’s Human Needs Theory. Burton states that recognition, security, and identity are the three basic Human Needs, which must be obtained in all aspects of life in order for conflicts or confrontations to be avoided and a quality of life to be achieved (35-6). For this analysis, recognition will be defined for migrants through the legal way in which they are viewed by the government of the country whose borders they reside within. The ways in which the security needs of this group are met is then defined by this label of recognition, as the oftentimes limited health resources migrants will have access to depend upon this given label. Ultimately, through the ways in which the recognition and security of these groups are defined, a conflict emerges. As the health vulnerabilities faced by Burmese migrant women are not met, these same health vulnerabilities become threats to the Thai community as a whole. As a threat to the Thai society, the identity of migrants is quickly pre-determined. Even though Thailand has led the world in its HIV/AIDS programs, its failure to recognize and provide care for the

migrant groups from Burma has the potential to jeopardize the efficacious successes had there in the past (Hearst 42).

In addressing the health needs of Burmese migrant women, this analysis will first present background information on the stances taken by both Burma and Thailand in their attempt to eradicate HIV/AIDS from within their borders. Secondly, the recognition, security, and identity of the Burmese migrant women, as it is shaped primarily by external forces, will be addressed, highlighting the correlation between the recent influx of migrant women, specifically into the sex trade, and the recent spike in HIV/AIDS rates in Thailand. The health vulnerability of these women is thus defined; it is concluded that their high health vulnerability endangers the Thai community because of the nature of their work, the risks of HIV, and the biological way in which it is spread. Until Thailand recognizes the undeniable links among the Burmese migrant women in the sex industry, HIV rates, and their own failure to address socioeconomic needs of migrants, this issue will not be addressed, allowing for HIV rates to flourish and the human rights of both migrants and Thais to be disregarded.

Background Information: HIV/AIDS in Burma and Thailand

Because of the climate of political conflict within Burma, many key issues that must be maintained in order for a people to have a quality of living are overlooked, including the HIV/AIDS epidemic. In Burma, “HIV infection has penetrated virtually all population groups and all geographic locations” (Chandler 255). The earliest HIV records are from 1993, documenting around 7,500 cases. However, the following year, the HIV infection rates were marked at between 400,000 and 500,000 people (254). This drastic increase in documented cases can be contributed to an increase in testing capacity and

overall awareness by the Burmese government and World Health Organization, in addition to an actual increase in cases, many of which have been linked to intravenous drug use, the sex trade industry, and high transience of certain at-risk populations (including “truck drivers, traders, day laborers, fishermen, and miners”) (253). The Burmese government records high rates of heroin use, with seventy-four percent of users in the former capital, Rangoon, found to be HIV positive in 2004 by the International Crisis Group. Additionally, in that same year, one-third to one-half of sex workers in both Rangoon and Mandalay were found to be HIV positive. BBC speculates that, if calculating all vulnerable groups, “potentially more than 7% of the population is infected” (Jagan). Patrick Stefford has noted that Burma’s HIV rates have remained high, even comparing their current statistics to the state of Thailand in 1988 (17).

Certain health-based policies upheld by the Burmese government have also contributed to present state of HIV/AIDS within Burma. One example of a health violation is in condom laws: condoms were illegal in Burma until 1993, and even now, their high prices are accompanied by a general distrust, resulting in their low usage rates (Chernov-Hwang). Due to high infection rates and the prevalence of the sex industry, the lack of condoms was a certain factor in allowing for the spread of HIV. “In Burma, health expenditures fell from less than 0.38 percent of GDP in 1994 to 0.17 percent in 2000. As a result, most citizens must pay for what little treatment they can get. Because of laws that forbid the Burmese from forming independent organizations, private citizens and communities cannot organize self-help efforts to compensate for the government’s inaction” (*Burma: Time for Change* 19). Presently, Burma spends somewhere between one and three percent of its GDP on health care, and although the United Nations Joint

Programme on HIV/AIDS (UNAIDS) “gives no figures for government spending on HIV/AIDS programs, it does state that only 7% of HIV infected women and men are receiving antiretroviral therapy” (“Chronic Emergency: Health and Human Rights in Eastern Burma” 16; Stefford 15). Oddly enough, the Burmese government has also prohibited international health organizations from entering the country to provide services to its people; this was made out of fear of the scrutiny on its policies this would induce (“Chronic Emergency: Health and Human Rights in Eastern Burma” 20). Clearly, a “silent emergency,” as it has been called, is present within Burma (*Burma: Time for Change 18*).

As neighbors, the approaches taken by Thailand and Burma could not have been more different. “In Thailand, the spread of HIV began with a burst of transmission among intravenous drug users, but soon thereafter, 90% of transmission had become heterosexual” (Hearst 42). In 1993, in reaction to these statistics, the 100% Condom Campaign was developed, distributing sixty million free condoms each year to sex workers and their clients (Stachowiak 108). It mandated all paid acts of sex to be performed with the use of condoms, acknowledging not only the existence of brothels and the sex industry, but also the prevalence and stability of the underground economy. Instead of trying to eradicate the brothels, the Thai government chose to work within the pre-existing (highly successful and prevalent) economic system. The strategy within the 100% Condom Campaign was not to alter the prevalence of sex in Thailand, but rather, to alter the behavior during sex to include the use of condoms (Chernov-Hwang). The success of the campaign was measured by Sexually-Transmitted Infection (STI) rates in clients as well as sex workers; as these rates dropped and remained low, the campaign

was considered a success (Hearst 42). “After an explosive outbreak from 1988-1994, Thailand’s rates of infection among its reproductive-age adults have fallen steadily, from a high of over four percent of all adults, to under two percent in 2001” (Stachowiak 108). The approach emphasized not only increased condom use but also established the importance of a decrease in the number of partners, and as awareness spread, clientele dropped in brothels and brothel owners who were unwilling to cooperate were punished with fines or foreclosure (Hearst 42).

Despite the success of this campaign among Thais, it was not 100%, as it claimed to be, because it failed to promote these changes among the non-Thai populations that worked within the sex industry, a majority of which are Burmese (Leiter 92). “The campaign failed to reach the trafficked and/or lowest-end, brothel-based workers, since commercial sex venues with the worst conditions may be the least known to public health authorities, and thus the most inaccessible” (92). Lastly, because of the success of the campaign, as seen in the drop in newly contracted HIV rates and in response to the Asian Financial Crisis of 1997, the Thai government shrank the funding pool and social emphasis of the campaign. The UNAIDS 2008 Epidemiological Fact Sheet shows the decrease of HIV rates, from around 800,000 to, in the following years, 600,000. However, resulting from this funding shrink was a wave of new HIV/AIDS infections. This peak is also represented in this same graph (“Epidemiological Fact Sheet on HIV/AIDS: Thailand”).

As one of the world’s leading examples of a success story in the lowering of HIV infection rates, Thailand is now experiencing a new health risk; the influx of migrant women who are, because of their origins, journeys, and destinations, at high risk for

HIV/AIDS exposure, and because of their likely place of employment, stand as potential risks for the spread of the disease as well. Thailand has signed numerous international treaties that “legally bind the government to protect the panoply of rights for all individuals who live in Thailand, regardless of citizenship” (Leiter 104). These include the “International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination and Discrimination Against Women, and 13 International Labor Organization conventions, ... the International Trafficking Protocol in 2001, and [Thailand] has acceded to the Convention against Transnational Organized Crime” (104-5). As Thailand has seen and acknowledged both its ability to counter the spread of HIV and the need to protect the rights of people living within their borders, it is curious and potentially incriminating that not more is being done to address the needs of the Burmese migrants who do reside within their borders. Overall, there is an undeniable relationship between the well being (defined as free from threat/fear of HIV/AIDS prevalence) of Thais and the well being of Burmese living within Thailand. This correlation and imminent threat will be discussed in greater detail to come.

Who Are Refugees: Thai Recognition of Female Burmese Migrants and Others

According to the United Nations High Commissioner for Refugees (UNHCR), the internationally recognized definition of migrants include individuals who “make a conscious choice to leave their country of origin and can return there without a problem... it is safe for them to return home” (“Definitions and Obligations: Who Is a Refugee?”). As shown above, there were about 910,000 migrants who entered Thailand from Burma in 2004 alone who have registered for work permits (“Migrants Health and

Vulnerability to HIV/AIDS in Thailand” 12). The internationally recognized definition of a refugee is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..." (“Definitions and Obligations: Who Is a Refugee?”). As shown above, there are about 150,000 recognized refugees living within Thailand (Barron 16). The internationally recognized definition of an illegal migrant is an individual who “enter[s] a country without meeting legal requirements for entry, or residence (“Definitions and Obligations: Who Is a Refugee?”). The numbers of unregistered migrants is inaccessible data, but it is presumed to be in the millions (“Migrants Health and Vulnerability to HIV/AIDS in Thailand” 12).

Undocumented migrants are, on average, the same people as migrants and/or refugees, but they do not carry the proper paperwork or may have fled out of desperation without time to gather proper identification to gain that status. “Therefore although the only means of escape for some may be illegal entry and/or the use of false documentation, if the person has a well-founded fear of persecution they should be viewed as a refugee and not labeled an 'illegal immigrant' ” (“Definitions and Obligations: Who is a refugee?”).

The various definitions provided highlight the complexity of labeling the people affected by the Burmese conflict and all peoples in this situation. However, due to the international paradigm that demands such labels to then define subsequent actions, the labeling is necessary and the accuracy with which people are labeled will define what they are then considered to be entitled to by the international community and thus, what they receive. Inaccuracy in labeling has the potential to increase the health vulnerability

of an individual and thus, other individuals with whom which contact may be made. Therefore, the importance of accurately labeling is clear, as many people are affected with the assignment of each label.

The case study of the Thai-Burma border is an example of the grayness between these definitions, due to the high number of people who are forced to flee at a moment's notice, creating a large population of undocumented workers that, with proper documentation, could be labeled as either migrant or refugee, thus increasing their access to resources, opportunities, and the likelihood that their human rights would be upheld. Additionally, it is possible that the migrants within Thailand would also qualify as refugees, which, similarly, could provide greater access to resources, opportunities, and the likelihood that their human rights would be upheld.

Although this case study is choosing to focus on migrant women, their population is inextricably linked to all refugees and illegal migrants within Thailand because of the nature of the conflict all are fleeing and the difficulty faced in gaining one status over the other. This case study is presuming that the majority of individuals residing within Thailand have fled Burma because of their fear of persecution by the Burmese government, as a result of some of their mentioned policies. Therefore, within this analysis, the legal difference between migrants, undocumented migrants, and refugees is noted, and the haziness surrounding their recognition is yet another barrier in the research process. The majority of people living within Thailand are presumed to be documented migrants as there are records of these people, but the certainty of that assumption is wholly undeterminable because of the difficulty had in tracking undocumented people. Overall, the importance in noting the haziness of these definitions suggests that the

factors that lead to health vulnerability that will be presented below are factors present in the lives of migrants, both documented and undocumented, and refugees. Therefore, it is irrefutable that many more individuals than those that are presented in this study are affected by this conflict and the subsequent health vulnerabilities, but again, this number is unavailable.

Health Security of Female Burmese Migrants within Thailand

Because of the political situation in Burma, the manner in which those who cross into Thailand determines how they are recognized by the Thai government, thus determining their status, and subsequently, their futures. Simply crossing the border is potentially dangerous for women, especially when crossing alone or with other women and/or children. Without the protection of someone who knows the area or of a male figure, these women put themselves in danger of misstepping in a heavily land mined area, encountering situations conducive to rape or abuse from soldiers, police, brokers, etc. (Leiter 97). The more perilous methods of entering the country include paid brokerage and smuggling. Smuggling is often not done on request of the woman, thus the dangers are evident and as out of the control of the woman as is their role in the transaction. Secondly, paid brokerage is an act where a third party is hired to escort an individual or group across the border with the expectation of being delivered to a place of employment upon arrival (97). Overall, by crossing into Thailand, Burmese women are at risk of contracting HIV because of the dangers associated with the border regions, most of which are associated with sexual misconduct by men. Rape by both the Burmese and Thai army is commonly reported, although no official report has been released on trends

or numbers (Et-Twa). This poses a clear threat to the health vulnerability of women, putting them in danger of coming into contact with the HIV virus.

The overall access to health and medical resources had by Burmese migrant women is largely defined by the status given them upon entering the country. As a migrant, when applying for a work visa, as of 2004, it also became necessary to apply for health insurance (“Migrants’ Health and Vulnerability to HIV/AIDS in Thailand” 21). This costly process is likely to deter some migrants from obtaining a work visa, which in turn, jeopardizes their employment security. Additionally, a migrant that does register and obtain insurance often faces difficulty in traveling to the location of their assigned practitioner, as this relationship is predetermined and not dependent upon the request of the migrant. A third difficulty faced is due to language barriers (22). Undocumented migrants also have been recorded as fearful of being turned into the police, albeit after they are served within a medical office (21). Overall, the complications in accessing health care while protecting one’s security creates challenges for Burmese migrant women who cross into Thailand. These complications are then manifested in the tools had by these women surrounding the topic of HIV/AIDS and their ability to address their own needs. Some of these factors include: learning of the disease, determining when a doctor’s visit is appropriate, contraceptive and protection methods, and child and prenatal care (“Assessment of Mobility” 2).

In addition to these ways through which Burmese migrant women may access health care in Thailand, there are a variety of other resources that are in the northern Thai-Burma border area to address specifically their HIV health concerns. The Mae Tao Clinic was established in 1988 just inside the Thai-Burma border in the aftermath of

student uprisings that were brutally crushed by the military junta (Et-Twa). This clinic is one of the few resources for migrants to receive medical care in Eastern Burma and Thailand. HIV/AIDS is becoming a greater concern for the clinic due to the increase in number of cases recorded each year. “In the six-year period 1998-2004 the number of cases [of HIV] detected in antenatal care (ANC) clients screened doubled from 0.8% to 1.54%... On the basis of these averages we estimate there are between 1,800 to 2,250 persons living with HIV/AIDS in our catchment population of 150,000 persons” (“Health Services: HIV/AIDS Prevention”). Until 2007, the clinic had partnered with an organization that provided ART medications for HIV/AIDS patients. However, because of the conditions regarding the transience and mobility of the migrant population as mentioned above, the distribution of these medications, during the period that the program existed, was unreliable (Et-Twa). Additionally, the Mae Tao Clinic is partially funded by the Thai government, as are a few of the local NGO’s listed below, which is the prime way in which the Thai government, besides allowing/requiring migrants to have health care, provides for the health needs of this specific group of people living within their borders (Et-Twa). It is clear that HIV is a concern for this region and the people therein.

There are numerous other NGO’s that provide medical and HIV care for migrant women. One source of aid relief is the Back Pack Health Workers Team (BPHWT). Their aim is to equip people with the skills necessary to address their basic health needs. As transient as the people they serve, the BPHWT move about carrying supplies and holding training sessions at various villages and communities within the northern border region of Burma and Thailand (“Chronic Emergency: Health and Human Rights in Eastern Burma”

23). Most importantly, what is provided by the BPHWT is quick care in remote regions and some of the only records of health needs, morbidity and mortality indicators, and human rights abuses for these people (24). While acknowledging the unavoidable shortcomings of their records due to the unregulated conditions under which they must conduct their research, this group supplies otherwise unnoted data. Some other international organizations include UNAIDS, UNHCR, the American Rescue Committee, Aide Medicale Internationale, and unicef (25-7). In addition to the Mae Tao Clinic, there are a variety of local NGO's that work to support the overall structures of society that contribute to the conditions faced by migrant woman that leave them at risk for contracting HIV, including the Tak Border Child Assistance Foundation, the Taipei Overseas Peace Services, the Karen Women's Organization, the Human Rights Education Institute of Burma, and the Kachin development Networking Group, among others (Et-Twa). These groups provide, with some assistance from the Thai government in the form of funding, various services necessary for the treatment of HIV. Despite their best efforts to meet the needs of a transient population also living under great risk,

Within the structures established by the NGO's, the difficulties faced and failures of both the Thai and Burmese government to meet the needs of migrant women are highlighted. Not only is the trek into Thailand dangerous, posing risks for the exposure to HIV, once within Thailand, the medical resources are limited. Additionally, other resources need to be supplied, including shelter, food, rights education, and others, because when on the run, very little can be carried. Undoubtedly, however, being recognized as a migrant allows for a wider range of medical choices than one would find as an undocumented worker (Et-Twa).

Without knowledge of condom use, where condoms can be obtained, where HIV testing occurs, and what experiences/symptoms necessitate such a test, a similar language as that of the practitioner, among other factors, both providing and obtaining quality health care for Burmese migrants is difficult.

Many key informants working with Burmese migrant women in Thailand underscored the fact that female migrants and trafficked women faced “exactly the same” issues in terms of exploitation at their destination, including sexual abuse, debt bondage and the transfer of debts to new employers, concerns over personal physical security, harsh living conditions, and lack of access to health care. (Leiter 98)

The Burmese women accept the services they do have access to, but a clear violation of Thailand’s signature on the numerous international treaties it has become party to is apparent as the adequacy of the ways in which the Thai government is fulfilling the needs of migrants is questioned.

The Likelihood of Becoming a Sex Worker

Upon arrival, the employment opportunities available to these women are numerous, yet limited in mobility and security. These women may be able to obtain a legal work permit or, if they have a social network already established, may be able to find work wherein they do not need a legal permit. However, without a legal work permit, an employer is not held to regulated standards and the female worker is without legal protection (Leiter 99). Some examples of work for females are garment or ceramic piece factory employee, domestic worker, seafood processor in a processing plant, and

sex workers (“Migrants’ Health and Vulnerability to HIV/AIDS in Thailand” 5-6). The prevalence of Burmese sex workers within Thailand is estimated to be between one-half to nearly ninety percent of all sex workers (Leiter 96, Barron 16).

The factors that lead these women into the sex trade include what has been mentioned above as well as their need for money, lack of alternative options, and overall desperation.

Further reasons had by women to enter into this industry are the dependents they may be responsible for, including children, parents, husbands, and siblings (*Sacrifice*). The sum of these experiences and needs, the ways in which the Thai government chooses to recognize Burmese migrant women, and the subsequent obstacles they then encounter lead migrant women into a life in a brothel. Attributed to the failure of the Thai government to recognize Burmese women in the 100% Condom Campaign as well as the low-end brothels, and because of their limited access to health resources, Burmese sex workers are at risk of not being provided condoms in their place of employment or being allowed to deny a customer services when denied the use of a condom (*Sacrifice*). This denial is, ultimately, a denial for all parties involved. This trend has been recorded and it is where Thailand’s personal interest, its own people, becomes threatened.

An Unseen Threat within Thailand: Identity of Female Burmese Migrants

Burmese migrant women who work within the sex industry face threats to the stability of their health, as has been mentioned already; however, they pose a high risk to their surrounding environments as well, more so than migrants of other stature because of their sexual availability.

“Lack of access to health care for these women can often mean chronic infectiousness for

male partners, their wives, and a much wider circle of risk for the community than the physical brothels, truck stops, and bars in which these women toil” (Stachowiak 106). As has been shown, heterosexual sex is the leading cause of HIV transmissions in Thailand, much of which begins in the brothels. HIV is then spread within homes due to “sexual networking” of husbands, or the likelihood of husbands to have relationships with mistresses during which, they may or may not wear condom (Havanon 13). Additionally, it is very rare that condoms are worn during intercourse between married couples. There is a remarkably high prevalence of sex work as a destination; of the estimated 200,000 - 325,000 sex workers found in Thailand, an estimated 30,000 – 80,000 are assumed:

...To be undocumented migrants, the majority of whom are Burmese women. HIV prevalence is higher among Burmese sex workers than among Thai sex workers, in part due to their likelihood of having suffered the sexual risks associated with having been coerced or trafficked in sex work, as well as the fact that riskier low-end work is almost exclusively the province of non-Thai women. (Leiter 91)

“Thai female sex workers have been associated with the transmission of HIV infection from the late 1980’s onward” (Scambler 1856). This data corresponds with the beginning flows of Burmese migrants into Thailand due to the peak of violence within their own country. “HIV rates are approximately two to three times higher among trafficked Burmese sex workers in Thailand than among Thai women voluntarily working in the industry” (Stachowiak 106). Scambler et al. further supports the

possibility that Burmese migrant women have contributed to the HIV epidemic, as infection rates have continued to increase, mainly in stable relationships. “As many as half of new HIV infections each year occur within marriage or stable relationships, where condom use is typically low” (1856). Scambler et al. quotes Wawer et al. as finding that two-thirds of female sex workers found in Bangkok in the early 1990s came from the north, meaning both Thai northerners and Burmese migrants, and therefore draws the correlation between Burmese migrant women and the proliferation of the HIV virus through their presence in the Thai sex trade as well as the role had by Thai men (1857). Again, it is evident that more than one individual is affected by the health vulnerability of others. Because of the high number of women crossing the borders, the situations they face along the journey and once settled within Thailand, and the prevalence of married men-prostitute relationships, the HIV epidemic is spread. Also, this prevalence gives reason for the Thai government to be strict in its border control, as each individual has the potential to threaten the health of those already living within their borders.

Conclusion

Recent steps by both the Burmese government and the Thai government do provide hope for the HIV/AIDS situation in their respective countries and, as shown, in the other's country as well. Burma has recently approved of a needle exchange program to begin to counter the spread of HIV through the high rates of heroin use, has begun addiction treatment and rehabilitation centers, and has begun to make retroviral therapy more widely available to its citizens (Chernov-Hwang). However, in Burma, the response remains too centralized and still lacks a focus on the ethnic minorities, where the HIV prevalence is the highest within the country and whose members remain suspicious of the

government due to their tense history, as mentioned above. Additionally, prostitution remains illegal, so the government has limited ability to address one of the key factors in the propagation of the disease within their borders (Chernov-Hwang).

Since the emergence of the HIV epidemic, migrant populations have received considerable recognition from the international community in the context of risk, spread, and prevention of HIV/AIDS. However, despite the long recognition of migration's relationship to HIV vulnerability, states have largely failed to ensure that internal and international migrants have access to HIV treatment. ("Discrimination, Denial, and Deportation")

Burmese female sex workers as well as migrants are being labeled with stigmas that are harmful to the Burmese population in general. Not only do these stigmas have the potential to create further divisions between the populations, but they also have the potential to generate further disparities between the lives led by Thai people and the lives led by Burmese living with Thailand. Overall, it is obvious that the affects of HIV do not function on their own; many surrounding factors influence the vulnerability of Burmese migrant women, and thus furthering their likelihood of both contracting and spreading the disease.

Thailand's failure to notice the contribution of Burmese sex workers to the recent spike in the nationwide HIV/AIDS rates is threatening harm for both the Burmese migrant community as a whole as well as Thai citizens. Because of the vulnerable conditions under which Burmese migrants live, this group is more susceptible to contracting HIV/AIDS. As a result of the employment Burmese women often find within

Thailand as sex workers, their vulnerability ultimately becomes the vulnerability of all Thai citizens that engage in this kind of behavior. However, even those who do not choose to engage in prostitution and the sex industry can be affected by others who do, such as husbands who may not be fully committed to a monogamous relationship.

The paradigm within which public health research is framed often makes a few basic assumptions, one of which includes the belief that “everyone has the knowledge and the resources to make free choices” (Altman 2003). The concept of health vulnerability contradicts that assumption, as will be exposed in this case study of the Thai-Burma border. Much of what was presented within this case study presented the Burmese migrant women as victims of greater social ills outside of their control. The responsibility had by these women to address their own needs is, of course, present. However, due to the extreme conditions that are working against the likelihood of their human needs and rights being met, much of the responsibility in this situation is handed over to the NGO’s for distributing services and information; to the police and army in the request to truly uphold the rights of citizens; to employers to maintain labor laws and the security of their employee; to medical practitioners to maintain patience through language differences and their determination to care for the well being of all peoples; and most importantly, to the governments, to stand by the international treaties they have signed. The request is made for governments to fully recognize the importance of each individual within society, regardless of their citizenship status, as it has clearly been shown that ignoring the presence and importance of one group or individual does have the potential to create a harmful situation for an entire, protected society. “The Refugee Convention says that states should not impose penalties on individuals coming directly

from a territory where their life or freedom is threatened on account of their illegal entry” (“Definitions and Obligations: Who is a refugee?). It is up for debate, whether or not Thailand could be incriminated on this account.

By disengaging its responsibility to uphold the human rights of the Burmese migrants, as agreed to within the numerous international treaties they have signed, Thailand is generating a public health crisis for their own citizens. In this case study, the usual tension between the paradigms of public health and human rights is suspended. In reality, only by engaging both paradigms will the Thai government be able to solve for the conflicts that are emerging and fulfill the human needs of security, recognition, and identity of the Burmese people. The potential crisis cannot be remedied without addressing both paradigms for both groups of people.

Works Cited

- “Assessment of Mobility and HIV Vulnerability among Myanmar Migrant Sex Workers and Factory Workers in Mae Sot District, Tak Province, Thailand.” *UNAIDS*. 2005. Print.
- Annan, Kofi. “Kofi Annan – Nobel Lecture.” *NobelPrize.org*. 10 Dec. 2001. Web. 15 Dec. 2009.
- Altman, Dennis. “Rights Matter: Structural Interventions and Vulnerable Communities.” *Health and Human Rights* 8.2 (2005): 203-13. Web. 10 Oct. 2009.
- Barron, Sandy, and Masaru Gato. *Between Worlds: Twenty Years on the Border*. Bangkok, Thailand: Burmese Border Consortium, 1994. Print.
- Barnett, Tony and Alan Whiteside. *AIDS in the 21st Century: Disease and Globalization*. New York: Palgrave Macmillan, 2002.
- Bennett, Trude. “Reproductive Health in Southeast Asia.” *Public Health Reports* 114-4 (1999): 374-6. Web. 13 Oct. 2009.
- Beyrer, Chris. “Burma and Cambodia: Human Rights, Social Disruption, and the Spread of HIV/AIDS.” *Health and Human Rights* 2:4 (1998) 84-97. Web. 10 Oct. 2009.
- Burma: Time for Change*. New York: Council on Foreign Relations, 2003. Print.
- Burton, John. *Violence Explained*. Manchester: Manchester University Press, 1997.
- Chernov-Hwang, Julie. *Southeast Asian Politics and Government*. Goucher College. Baltimore, MD. 9 Nov. 2009. Class.
- “Chronic Emergency: Health and Human Rights in Eastern Burma.” *Back Pack Health Worker Team*. 2006. Print.

“Discrimination, Denial, and Deportation.” *Human Rights Watch*. 18 June 2009. Web. 15 Dec. 2009.

“Definitions and Obligations: Who Is a Refugee?” *UNHCR*. 2009. Web. 15 Dec. 2009.

“Epidemiological Fact Sheet on HIV/AIDS: Thailand.” *UNAIDS/WHO*. Geneva, Switzerland, 2008. Web. 14 Dec. 2009.

“Epidemiological Fact Sheet on HIV/AIDS: Myanmar.” *UNAIDS/WHO*. Geneva, Switzerland, 2008. Web. 14 Dec. 2009.

Et-Twa. Personal Interview. 8 July 2009.

Farmer, Paul. “On Suffering and Structural Violence: A View from Below.” *Daedalus* 125:1 (1996): 261-283. Web. 15 Dec. 2009.

Freedom House. 2007. Web. 15 Dec. 2009.

“Myanmar: Update on HIV/AIDS Policy.” *International Crisis Group*. 16 Dec. 2004. Web. 16 Dec. 2009.

Havanon, Napaporn, Anthony Bennett and John Knodel. “Sexual Networking in Provincial Thailand.” *Studies in Family Planning* 24:1 (2003) 1-17. Web. 15 Dec. 2009.

Hearst, Norman and Sanny Chen. “Condom Promotion for AIDS Prevention in the Developing World: Is It Working?” *Studies in Family Planning* 35:1 (2004) 39-47. Web. 15 Dec. 2009.

Jagan, Larry. “Burma Faces AIDS explosion.” *BBC News*. 25 Sept. 2001. Web. 17 Oct. 2009.

Kilmarx, Peter H., et al. "HIV-1 Seroconversion in a Prospective Study of Female Sex Workers in Northern Thailand: continued High Incidence Among Brothel-Based Women." *AIDS* 12.14 (1998): 1889-98. Web. 13 Oct. 2009.

Leiter, Karen, et al. "Human Rights Abuses and Vulnerability to HIV/AIDS: The Experiences of Burmese Women in Thailand." *Health and Human Rights* 9.2 (2006): 88-111. Web. 9 Oct. 2009.

"Health Services: HIV/AIDS Prevention." *Mae Tao Clinic*. 2007. Web. 14 December 2009.

"Migrants Health and Vulnerability to HIV/AIDS in Thailand." *Prevention of HIV/AIDS Among Migrant Workers in Thailand*. Brahms Press.

Sacrifice. Dir. Ellen Bruno. Brunofilms, 1986. Film.

Say, Saw Gaw. "Living in Worry and Fear: Everyday life for villagers in Karen State." *Burma Issues Newsletter*. The Peace Way Foundation. Aug. 2007. Web. 14 Dec. 2009.

Scambler, Graham, and Frederique Paoli. "Health work, female sex workers and HIV/AIDS: Global and Local Dimensions of Stigma and Deviance as Barriers to Effective Interventions." *Social Science & Medicine* 66 (2008): 1848-62. Web. 10 Oct. 2009.

Strefford, Patrick. "The Response of International Donors to Myanmar's Escalating Health Crisis." *Ritsumeikan Annual Review of International Studies* 5 (2006): 37-57.

Stachowiak, Julie and Chris Beyrer. "Health Consequences of Trafficking of Women and Girls in Southeast Asia." *Brown Journal of World Affairs* 5:1 (2003): 105-117. Web. 15 Dec. 2009.

Ward, Martha C. "A Different Disease: HIV/AIDS and Health Care for Women in Poverty." *Culture, Medicine, and Psychiatry* 17 (1993): 413-430. Web. 13 Oct. 2009.