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Experiences and Beliefs About Violence and Sexual Health: A qualitative analysis of the experiences of female migrant Lao workers at the border of Thailand and Laos

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Abstract

Background: It is estimated that 10% of Thailand's total labor force is estimated to be made up of migrant workers. While the exact number of migrant workers from nearby countries is unknown, border towns and provinces are acknowledged to utilize a large population of undocumented and documented migrant workers. A majority of undocumented and a nearly half of documented migrants were reported to be female. While previous research has explored the health needs of female migrant workers in specific industries, such as the sex work industry and manufacturing industry, few studies have examined the health needs and beliefs of female migrant workers across a variety of industries. Furthermore, there is a paucity of literature of the experiences of female Lao migrant workers who work in Thai border towns. ***Objectives:*** The objective of this study is to characterize the health beliefs and needs of female Lao migrant workers (FLMW) in Thailand. ***Methods:*** Relational context analysis was conducted from 12 focus groups and 14 in-depth individual interviews (n=26). ***Results and Discussion:*** The two primary topics, under which several key themes were identified, were beliefs and experiences of violence and sexual and reproductive knowledge. Violence served as a ritual of atonement to dispel bad karma and often primarily as a punishment occurred during arguments about financial responsibility. FLMW held negative perceptions and beliefs about menstruation but felt confident in their knowledge of contraceptives. Among current and former FLMW who worked as sex workers, women felt encouraged to engage in unsafe sex practices and not learn about sexual and reproductive health in order to be more competitive. ***Conclusion:*** These study findings underscore the importance of educational empowerment interventions to address the health needs of FLMW that can further connect them to relevant health and social services.

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Introduction

In Thailand, there are approximately 3.9 million migrant workers from nearby countries, including Cambodia, Myanmar, Vietnam, and the Lao People's Democratic Republic (UN, 2019). Due to their varied backgrounds, migrant workers as a population encompass highly skilled and unskilled workers, which make it difficult to create exact estimates as to how many migrant workers work in each sector. However, some sectors that are acknowledged to have large populations of migrant workers are: agriculture, fishing, manufacturing, domestic work, seafood processing, and service (UN, 2019). Overall, approximately 10% of Thailand's total labor force is estimated to be comprised of migrant workers (UN, 2019). The objective of this study is to thus characterize the health beliefs and needs of female Lao migrant workers (FLMW) in Thailand.

While current estimates of the number of undocumented migrant workers are unknown, previous estimates have suggested over 1.5 million undocumented migrant workers work in Thailand (Suphanchaimat, Putthasri, Prakongsai, & Tangcharoensathien, 2017). Similarly unknown, is the number of undocumented migrant workers who engage in sex work, although the phenomena is recognized to include a significant portion of women by international and national organizations (Barmania, 2013; UN, 2019). While women make up approximately 48% of the migrant workers population that operate within formal sectors, the number of female migrant workers is expected to be much higher in informal sectors, like the sex work industry, due to the lack of viable employment in formal labor sectors (UN, 2019). Thus, without access to jobs in the formal sector, many female migrant workers take jobs in the informal sector and are therefore ineligible for formal migrant documentation in Thailand (Barmania, 2013; Nilvarangkul, McCann, Rungreangkulkij, & Wongprom, 2010; UN, 2019).

In Thailand, border towns present a unique context for its residents and especially for migrant workers. Due to the geographic proximity of Laos and the similarities (cultural and linguistic) it shares with Thailand, it is relatively easy for Lao people to work in the province (Molland, 2010, 2012). However, the process of becoming a documented migrant worker is often arduous and complicated and requires filling out several different visa applications (Molland, 2010, 2012; Rungmanee, 2016; Tangmunkonvorakul, Musumari, Srithanaviboonchai, Manoyos, & Sugumitot, 2017). People who cannot afford to pay for the forms and visas required in the process, thus enter the country as undocumented migrant workers and hide the fact that they are Lao (Molland, 2010, 2012). Not only is travelling into the country as an undocumented worker extremely difficult, but to do so, many people contract brokers to smuggle them in (Molland, 2012). In doing so, individuals incur a debt to the broker that they must pay before they can earn money for themselves and their families (Molland, 2012). These brokers operate a human trafficker, who additionally seek out, coerce, and/or buy teenagers, and young adults into working in exploitative industries (Molland, 2010, 2012; Rungmanee, 2016). As such, while deportation may create opportunities for individuals to return to their home communities, it can often result in the return to poverty or a situation where they are sold again. For Lao migrant workers, living in a Thai border town is both a blessing and a curse: it enables them to earn money, but they are forced to live in fear of being discovered and deported.

Undocumented migrant workers in sex work are often particularly vulnerable as they have usually experienced severe disparities in literacy, education, and wealth which resulted in sex work being the only viable means of work for them (Meyer, Robinson, Abshir, Mar, & Decker, 2015). While Thailand does have a universal healthcare system, this health care is only available for purchase to documented migrant workers (Barmania, 2013; Kusakabe & Pearson,

2016), and thus is not applicable to this population that desperately needs its services. Due to the aforementioned disparities, accessing affordable health care and utilizing effective reproductive health care is an extremely difficult process for undocumented migrant workers (Kusakabe & Pearson, 2016; Suphanchaimat et al., 2017). Furthermore, the looming fear of deportation makes it even more difficult for these women to ask for help from organizations that may assist them (Suphanchaimat et al., 2017).

Previous research has identified migrant workers, regardless of documentation status, to have an increased risk of experiencing violence and coercion (physical, psychological, sexual, and financial) compared to non-migrant workers (Moyce & Schenker, 2018). In particular, undocumented female sex workers were noted to be disproportionately impacted by patrons, partners, and strangers (Rushing, Watts, & Rushing, 2005). Regardless of the profession, people who experience violence are at increased risks of depression, anxiety, suicidal ideation, and chronic disease (Coker et al., 2002; Dougé, Lehman, & McCall-Hosenfeld, 2014; Rössler et al., 2020). Undocumented women in general are also at an increased risk for violence and physical and psychological chronic illnesses (Hacker, Anies, Folb, & Zallman, 2015). Additionally, undocumented workers have been noted to experience other barriers such as lack of social support, financial constraints, lack of transportation, knowledge deficits, fear of judgement, and shame that prevent them from reporting violence or accessing available care (Goldenberg, Rocha Jimnnez, Brouwer, Morales Miranda, & Silverman, 2018; Kusakabe & Pearson, 2016; Malhotra et al., 2013; Meyer et al., 2015; Reza, Subramaniam, & Islam, 2019). Thus, undocumented female workers sit at a unique intersection that predisposes them to violence and subsequent chronic health conditions. Public health research and interventions are needed in order to

understand and address the contextual factors that impact the health of undocumented female workers in all sectors to improve the health of this vulnerable population.

This study is novel and timely in that little research to date has been done to explore the health experiences of undocumented migrant women in rural Southeast Asia across multiple occupations, much less analyzing their health beliefs and experiences. Due to the unique intersections of gender, geographic location, documentation status, and violence that undocumented Lao migrant workers live in, it is vital that more research focus on the health of this extremely vulnerable population. Furthermore, while this research may be focused at the border of Thailand and Laos, the findings are likely to be generalizable to undocumented workers in other countries as well. This research will fill the gaps in the literature by examining and characterizing the health beliefs and needs of FLMW across a variety of occupations and ages and make relevant public health recommendations. Through understanding the health beliefs and needs of FLMW as a larger group, more community level interventions can be designed to address the health concerns of this vulnerable population.

Methods

Setting and Participants

This qualitative study was conducted between October 2018 and August 2019 in Northeastern Thailand, at the border of Thailand and Loa PDR (Ubon Ratchathani (Ubon), and Champasak provinces).

A Community Advisory Board (CAB) was created to guide and provide inputs and suggestions, including recruitment, to the study investigators. Members included current and former Lao migrant workers, a member of local non-governmental organization (NGO) who

works with migrant workers, a local Thai health care provider, a Lao health care provider, a member of a Lao NGO who works with migrant workers, local Thai business owners, and community leaders from the provinces.

With guidance of the CAB, groups of relevant participants were identified as critical groups to answering the research question, which included villagers from the provinces, former Lao migrant workers, current Lao migrant workers, local healthcare providers, local government officials, and local NGO workers. Participants were recruited purposively after receiving guidance from the CAB to maximize heterogeneity among groups identified as critical.

After identifying critical groups, several types of qualitative data were gathered. This study, utilizes a subset of this data, including 12 focus group discussions (FGDs, comprised of 5-6 persons per group) and 14 in-depth one-on-one interviews that were conducted. The total number of participants for this study is 41 (n=26). This subset was selected to focus on their wide range of sexual and reproductive health beliefs and needs as FLMWs.

Qualitative Measures

In-depth interviews were utilized because they allow researchers to explore targeted areas of inquiry which is critical to developing a more nuanced understanding of the health experiences and perceptions of FLMW. Each interview and FGD were audio recorded and conducted in a safe, private area after informed verbal consent was obtained. The duration of each FGD and interview ranged from 60 to 90 minutes and was conducted in Thai. Sometimes these interviews were conducted in the Northeastern dialect or Lao, depending on the preference of the study participant. All interviewers had at least a bachelor’s degree, with most holding an M.D., and were rigorously trained in qualitative research methods and interviewing.

Interviewers, who were predominantly female, also had at least five years of experience working with migrant workers and other vulnerable communities. After the interviews and FGDs were completed, the audio recordings were transcribed into Thai or Lao. FGDs and in-depth interviews were utilized, and a high number of participants were recruited to ensure the validity of the data using data and method triangulation.

Analysis

Transcriptions were translated into English by a certified translator and imported into NVivo (version 12) (QSR International, AU), after which the transcriptions were thematically coded. Additionally, after translation a bilingual researcher not involved with the data collection process read over the transcriptions to ensure coherency. After coding was complete, qualitative data was analyzed through relational content analysis (Le Navenec & Hirst, 2010; Robinson, 2011) to reveal emergent themes.

Relational content analysis posits that all codes are inherently meaningless unless they are considered and interpreted in relation to another code or overarching theme (Le Navenec & Hirst, 2010; Robinson, 2011). Under this paradigm, emergent themes are the concepts resulting from the relational comparison of multiple codes. Emergent themes of repeated health beliefs and experiences were therefore identified in this study after comparing and analyzing the relationship between codes that appeared proximal (in transcripts and frequency) to one another.

Although coding was primarily conducted by co-authors (RB and KK), the process and analysis was discussed with coauthors (PP and TG) to ensure reliability of data and appropriateness of themes. The discussion of codes and emergent themes is critical to the

analysis as the data was translated into English, but still must contain the appropriate Thai and Lao cultural context.

Human Subjects Protection

The research protocol was reviewed and approved by Institutional Review Boards at Mahidol University (IRB approval number 2015/458 (B2)) and Yale University (IRB approval number 2000027559). To ensure anonymity, all participants were given pseudonyms and the data was scrubbed of all identifying information.

Results

Participant Demographics

Twelve FGDs and 14 in-depth individual interviews were included in the qualitative analysis. Participants ranged from ages 19 to 56 years old and had occupational experience as a FLMW in several industries, including agriculture, manufacturing, business, janitorial services, and informal sectors (e.g. sex work and street vendors). A varied occupational history is a common phenomenon among FLMW and allows participants to speak to a wide array of experiences, which helps to create a more nuanced understanding of common realities for FLMWs.

Traditionally, research has examined the experiences of female migrant workers in specific industries (most commonly, farming and sex work). However, while this focus provides detailed industry specific insights, it fails to capture the diversity of experiences that exist among women who work in different industries or of those who transition between fields.

Relational Content Analysis Results

Among FLMW, two primary themes appeared: experiences with violence, and sexual and reproductive health knowledge. These themes were present across all three provinces and highlighted a wide range of sexual and reproductive health beliefs and needs that female migrant workers experienced.

<u>*Experiences and Beliefs About Violence*</u>

Most participants acknowledged experiencing some type of violence, primarily physical and verbal/psychological. The traditional values of Lao culture, and thus by extension that of that their families, emphasized deference to elders, family harmony, and moral duty/behavior. Several FLMW highlighted that importance of dressing in a conservative fashion and the socially enforced idea of male superiority. While some participants did not want to discuss violent incidents, when asked for additional details regarding an incident of experienced violence, others provided an unprompted explanation as to why the violence was acceptable, if not expected, often referring to previously discussed cultural expectations. The two most common subthemes revealed that violence was often considered to be a form of atonement and that violence usually occurred during arguments or discussions about financial responsibility.

Violence as Atonement.

FLMW felt that they often experienced violence as punishment for failing to act appropriately as a woman in their society. If an elder family member was the perpetrator of the violence, they were berated for being disrespectful or dressing inappropriately.

"Women should be reserved, stay at home, and dress politely. Never wear shorts, but normal pants, to go outside. But it's ok to wear shorts for sleeping. Never let men see you wearing shorts or touch your skin"—Sai, pseudonym, 27 years old, shop keeper

As a result, many FLMW felt more comfortable and relaxed in Thailand due to their looser cultural restrictions on how women should behave. Not only were they allowed to dress however they wanted, but they also explained that the reduced social restrictions between men and women made them feel less anxious.

As migrant workers, FLMW earned more money in Thailand than they would in Laos. Women were grateful for this economic opportunity and cited it as a main reason for working in Thailand but expressed the difficult re-adapting to life in the more socially rigid and conservation Laos was when they returned home. It was in this period of adjustment that FLMW would often result in a violent interaction with an elder family member.

Women also discussed how violence operated as a ritual of dispelling accumulated bad karma. Behaviors such as being non-deferential or argumentative with elder family members or men and being "overly familiar" with other men resulted in women accruing bad karma, because she was failing to be modest and challenging the familial hierarchy. This karma was seen as a major source of familial strife, poor luck, poverty, and general unhappiness. With this in mind, women explained that verbal or physical violence was a way to atone and make amends with their husbands or in-laws for disrespecting them and that enduring it would erase the bad karma.

"If you have a husband, you must give him respect. And you should not give respect to only him but also his relatives." –Soon, pseudonym, 52 years old, current self-employed forest forager

"Do a ritual to make amends to husband so that all the bad karma disappears and will not hinder us from earning a good living and having a smooth marriage life."—Soon, pseudonym, 52 years old, current self-employed forest forager

Violence was accepted as an unpleasant, but necessary part of life for FLMW. They believed that because they challenged the traditional social norms, which created discord within their families, that they had to atone for this behavior. Subsequently, women felt that they could not criticize the violent behavior that they endured and should instead strive to be adherent to the social norms, despite the fact that doing so felt as if they were silencing their own opinions. More than the violence, the shame and guilt women experienced as accumulators of bad karma left women feeling distant and resentful of their families and partners.

Violence as a Result of Financial Troubles.

FLMW, particularly those who were married, had difficulties negotiating how money was used in the family. Financial disagreements clashed with traditional Lao cultural values, which often led to violence altercations. The women felt that because they had earned the money that they deserved to have a say as to how money was spent. These feelings were especially common if a woman believed that the money she earned was being used inappropriately or selfishly (i.e. for gambling or a husband's personal expenses, as opposed to familial expenses).

> *"If we have money, I want to buy some jewelry and travel. But for husband, he would love to buy a new car. For me, I just want to have a big house and have some land to do farming. But I don't want to be the one who does it. I want to travel but my husband does not want to."—Mint, pseudonym, 42 years old, current coffee gardener*

> *"When [my husband] has money, he doesn't want me to keep it. I want to keep it myself because he usually spends with gambling and never wants to keep it for family."—Mint, pseudonym, 42 years old, current coffee gardener*

Women further lamented over the lack of financial and personal independence they had after they became married. Some women reported that they began working as a migrant worker as early as 13 years old and explained how they often had more freedom on how to spend their

free time and money (i.e. traveling or hanging out with friends). Yet, after they got married, they felt compelled to devote all their free time and money to their family. After having children women were expected to spend less time working and spend more time taking care of their home and their children, which led to feelings of social and financial isolation.

> *"When I was young, I hanged out a lot. Life was more fun. I went out to find a job with my friends. I went everywhere they took me to. But after I got married, life is more difficult. I only have to stay at home and raise my kids. These days I have to rely on my parents sometimes and my husband."—Taay, pseudonym, 23 years old, coffee gardener*

For FLMW money represented freedom and personal happiness, when they had control over how money was spent. However, cultivating that control was difficult as it created martial and familial discord. Martial and familial discord was rarely resolved through anything other than violence, even though other factors such as feelings of freedom, isolation, and fatigue play significant roles leading up to arguments. Ultimately, money became associated with family happiness only when women ceded financial responsibility to their partners or elders or after women experienced an incident of violence. Even so, women explained that the feelings of unhappiness, isolation, and fatigue did not diminish after a violent event, but continued to persist unspoken.

Sexual and Reproductive Health Knowledge

Although many participants acknowledged the importance of family planning, many explained that they only learned about anything related to sexual and reproductive health after they had been in Thailand for several years. Concepts such a STI prevention, positive relationship building, perinatal health, abortion, and infertility were rarely discussed in a family or community setting. FLMW very rarely received counseling on any of these topics from

medical professionals or village healers. Instead, FLMW explained that they learned about sexual and reproductive health practices from other, older workers at their jobs. Many attributed their lack of knowledge to their parent's personal lack of knowledge surrounding sexual and reproductive health. These FLMW explained that sexual and reproductive health were fairly taboo topics in their families and villages so even if they had questions, they rarely felt like they had people in Laos they could ask.

> *"Our parents are not educated so they don't know how to educate us. We mostly learn by ourselves. In the past, they still let us have a shower outside even when our breasts grow bigger. No one told us to wear a sarong."—Mint, pseudonym, 42 years old, coffee gardener*

Several women recalled childhood experiences with shame and embarrassment as they explained how they their family dealt with the changes happening in their bodies. While the women accepted some changes were "natural" and "expected", other changes were so rarely discussed that when they happened, they were terrified and confused. FLMW did not know how to manage their symptoms but refused to go to a medical professional as they knew that a visit would be expensive, and that it could jeopardize their ability to work in the country, if they were discovered to be working without a visa. The participants expressed vague feelings of inadequacy and shame when they compared their lack of knowledge to that of their Thai peers.

> *"At first, I don't know what happened to myself when it started bleeding. I feel a bit embarrassed and not confident to go anywhere because I have never had anything like this before. Unlike in Lao, Thai people, even young people, are more educated and know how to manage themselves when something like this happened. Let's say, Lao people are not as developed as Thai people."—Sai, pseudonym, 27 years old, shop keeper*

Negative Perceptions of Menstruation.

There was a clear general lack of knowledge about sexual and reproductive health issues among FLMW. For concepts women were familiar with, such as menstruation, there was a heavy stigma around talking about it and having it. Women widely viewed menstruation poorly and several explicitly called it “dirty”, “bad”, and “impure”. There were many reasons women held these beliefs, some attributed it to a pervasive social stigma, others misunderstood the biological function of menstruation, and some cited explanations from village elders.

> *“People believe that women who have a period should not be allowed to go to the temple. They will not let you in because they believe that it is not good. You have to be clean and pure to go to temples. People who have a period are believed not to be so clean because it could stink and stain their sarong. I just don’t know why. This is what the belief has been. Women during their period are not supposed to go to the temple because it is a sacred place. Christian church too will not let them in.”—Mint, pseudonym, 42 years old, coffee gardener*

> *“A period is bad blood from the body. It is rotten and giving a bad smell.”—Taay, pseudonym, 23 years old, coffee gardener*

Regardless of the reasons why a woman held these beliefs, menstruation was a widely disliked bodily function and that one woman dreaded. Some women further highlighted that when they were menstruating that they felt further isolated from others, who knew how to manage the bleeding so as to not bleed in a temple but did not want to ask for advice for fear of being discovered. These negative perceptions of menstruation also contributed to negative self-perceptions and poor self-confidence.

Perceptions and Use of Contraception.

Despite the lack of knowledge surrounding menstruation and other reproductive health issues, women did report high rates of contraception use. The most common form of contraception FLMW knew about and used were birth control pills. Their mothers, other older female family members, and visiting health care workers regularly impressed the importance of

family planning at a young age and especially before a woman began working as a migrant worker.

> *"Most of the time I just take birth control pills, which I can buy by myself. That's because I am afraid of having babies. My mom suggests I take it. A group of doctors, who used to visit our village, also suggest we do the same."—Som pseudonym, 26 years old, coffee gardener*

FLMW were confident in their ability to explain why they preferred one form of contraception compared to another and how it may impact their ability to work. Women also highlighted how discussing family planning was a common practice among young couples and something that both women and men were expected to be able to communicate about and make decisions about. Compared to other sexual and reproductive health concerns, contraception and family planning appeared to carry less negative stigma and FLMW were more comfortable talking to others about it.

> *"Usually doctors suggest we use IUD instead of taking birth control pills, which are not good. My boyfriend also said that getting a vasectomy is not good for us because we have a labor job and that will stop us from working hard. Having kids will also make our life difficult."—Bor, pseudonym, 27 years old, coffee gardener*

> *"I just use IUD. My doctor said that it can be used for up to 10 years. Healthcare staff in a hospital has put it inside for me. It functions well as long as your womb is normal."—Muk, pseudonym, 31 years old, coffee gardener*

While there were a few types of contraceptives that women felt less knowledgeable about, including diaphragms, cervical caps, and spermicides, the knowledge FLMW held about contraceptives made them feel empowered. In addition to personal self-confidence, women explained that knowing more about how to protect their bodies and take care of themselves made them feel happy, independent, and able to appropriately handle other challenges. FLMW were comfortable with relying on others but explained that they enjoyed being able to teach and help their friends and other women they knew with their knowledge.

Sexual Practices in Sex Work.

While not all FLMW are sex workers, numerous women had reported being involved with sex work at one point in their life or knew of someone who engaged in sex work. In this instance, female Lao migrant sex workers (FLMSW) had a very different experience compared to their former or non-sex worker peers.

Former and current FLMSW attested that sex workers held less sexual and reproductive health knowledge in general. Compared to those who were not working as sex workers, discussions about sexual and reproductive health were highly discouraged by FLMSW, clients, and karaoke bar owners. Women who had less sexual and reproductive health knowledge were seen as "purer" and more "willing to try anything" by clients and thus, more desirable than those who did have some knowledge. FLMSW believed that owners felt educating and enforcing safe sex policies were expensive and would drive away customers.

Furthermore, FLMSW admitted to feeling a persistent sense of competition with other FLMSW at their karaoke bars, which encouraged them to act recklessly and be less vigilant about their health. More customers, meant more money which they could send to their family, use to find their family, or build their life in Thailand. Furthermore, being more attractive to customers also gave then more opportunities to meet a Thai husband. Across occupations, FLMW shared a desire to marry a Thai man and live, permanently in Thailand. For several FLMSW this desire was amplified by the desire for independence and to escape poverty.

> *"Lao women migrant workers will try to compete with each other in their workplace [Karaoke bar]. Some of them try to attract customers by doing everything their customers asked without caring about diseases due to their lack of knowledge, which makes many customers like them. Some customers offer up to 10,000-20,000 baht to sleep with them. Some workers at first practiced protected sex with their boyfriend but later on they become more flexible about it. They will*

even let their partner, whom they especially like, cum inside. That's because they want to get pregnant. After getting pregnant, some women choose to return to Lao to deliver a baby before coming back to Thailand to work again. Some workers got married to their customers. Some of them get an abortion. In this case, if they were caught by the owner, they will get kicked out of their job. When equipped with more knowledge, these women will be braver in having their health checked."—Gaew, pseudonym, 19 years old, coffee gardener

Even though many former and current FLMSW viewed additional sexual and reproductive health knowledge as beneficial. Some FLMSW felt that it would not change the situation because they were unable to go to hospitals and get adequate medical care in both Thailand and Laos. Additionally, a few FLMSW mentioned that they would not feel comfortable seeking care because of how doctors would treat them and for fear of running into clients in the hospital or other health clinics.

Discussion

This study documents the wide range of sexual and reproductive health beliefs and needs female migrant workers experience. These women may work in a variety of different sectors, but all indicate how important sexual and reproductive health education is. Additionally, based on the pervasive sense of powerless conveyed in the interviews, it is vital that all educational interventions are empowering and demonstrate to female migrant workers how to utilize this new information. Furthermore, this qualitative analysis has illuminated how migrant workers need additional supportive services and interventions to address the violence that they have experienced. An empowering intervention would be similarly suitable for addressing the violence experienced by female migrant workers.

The findings about the causes of violence are consistent with previous research (Lu et al., 2012; Webber & Spitzer, 2010). Several studies on migrant workers in Southeast Asia have

noted how widely accepted violence is against women who shame or trouble the family (Bhuyan, Mell, Senturia, Sullivan, & Shiu-Thornton, 2005; Decker et al., 2010). Numerous other studies have further indicated that female migrant workers are particularly vulnerable to violence (Moyce & Schenker, 2018; Webber & Spitzer, 2010), which corroborates the findings of this study. However, the introduction of financial difficulties as a cause of violence has not appeared in many, if any, other studies. The intersection between economic success and violence has rarely been explored in studies focused on migrant workers.

Findings about a lack of knowledge related to sexual and reproductive health among migrant workers is consistent with previous research (Wahed, Alam, Sultana, Alam, & Somrongthong, 2017; Webber, Spitzer, Somrongthong, Dat, & Kounnavongsa, 2012; Webber & Spitzer, 2010). This phenomena has been found in several studies looking at migrant workers from Southeast Asia, East Asia, Europe, and South America (Espinoza et al., 2014; Goldenberg et al., 2018; King & Dudina, 2019; Lu et al., 2012). While this finding is not unique to Southeast Asian migrant workers, it does appear to be unique to migrant workers as a whole which indicates a global need for more comprehensive and formal sexual and reproductive health education. The negative perceptions of menstruation were also consistent with other studies (Asnong et al., 2018; Ussher et al., 2017), but the explicit belief that menstruation is dirty is a fairly novel interpretation. Unlike negative perceptions of menstruation, the use of contraception among female migrants in Thailand is inconsistent with previous studies of other female migrant workers (Asnong et al., 2018; Kim, Pham, Vu, & Schelling, 2012; King & Dudina, 2019; Lu et al., 2012). Other studies have focused primarily on condom usage (Decker et al., 2010; Ghimire, Smith, van Teijlingen, Dahal, & Luitel, 2011; Tangmunkonvorakul et al., 2017), but the findings in this study indicate that birth control pills and IUDs are more common and accessible to female

migrant workers. Unlike condoms, birth control pills and IUDs uphold a woman's autonomy, which may be one reason why these methods are more attractive for this population.

While female sex workers are a subpopulation of interest in this study, the findings about their sexual and reproductive knowledge and practices are consistent with studies of sex workers in other Southeast Asian countries (Decker et al., 2010; Ghimire et al., 2011; Phrasisombath, Faxelid, Sychareun, & Thomsen, 2012; Wahed et al., 2017; Webber et al., 2012). A large amount of the literature on female migrant workers has focused on sex workers and their sexual practices (Decker et al., 2010; Ghimire et al., 2011; Phrasisombath et al., 2012), which—including this study—has highlighted the frequency of inconsistent safe sex practices in order to maintain a client base (Ghimire et al., 2011; Phrasisombath et al., 2012). Yet this study adds another dimension to this issue in that it implicitly underscores how a lack of sexual and reproductive health knowledge can extend to a lack of knowledge about sexually transmitted infections (STI) and STI symptoms. This dimension is important because there is a paucity of literature on female migrant sex workers understanding of non-HIV STI and STI prevention.

Future interventions to address the health needs of female migrant workers should utilize several culturally-specific approaches to reduce violence experienced by and increase the sexual and reproductive health knowledge of female migrant workers, such as developing peer-education interventions to bolster knowledge (similar to the Neighborhood Mothers Project in Germany). Interventions designed to increase sexual and reproductive health knowledge should utilize an empowerment and/or a human-rights based approach to combat the pervasive lack of self-efficacy and leverage the common desire for control among female migrant workers. Empowerment interventions should also further utilize peer-to-peer modeling and education so as to bolster the self-efficacy and confidence of the female migrant workers who lead and receive

the intervention. To address the experiences of violence female migrant workers, endure, an approach that challenges the cultural norms of female subservience and provides social support and other services may be the most effective. However, with all the aforementioned interventions it is critical that they be revised and altered to be culturally-specific to female migrant workers working in Thailand and what sector they operate in.

Additionally, research and interventions should also be explored how FLMW of various occupations interact with and utilize local health care facilities. While previous research has highlighted that healthcare is financially and logistically difficult for migrant workers to access (Barmania, 2013; Kusakabe & Pearson, 2016), the findings in this study further indicate that other factors may be preventing women from accessing care. Several interviews with FLMW have revealed worries about judgement, related to their occupation and/or documentation status, and a fear that they may be identified by clients or coworkers. Research should be conducted to explore the perceptions health care workers in local hospitals and clinics have of FLMW as well as the privacy protocols in place at each location. In addition to professional training and restructuring in local clinics and hospitals, interventions should also be developed to create sustainable partnerships between local health care workers and female migrant workers.

There are several limitations in this study that should be noted. The first limitation is the small sample size of 12 focus groups and 14 interviews which limits the generalizability of this study. Second, the nature of qualitative research indicates that the data gathered can be interpreted in multiple ways. Third, there is the possibility of social desirability bias in our study given that FLMWs are a vulnerable population and that discussion about violence, and sexual and reproductive health are often considered taboo. The participants might have felt uncomfortable or been afraid of judgement if they discussed particular topics, such as abortion,

or condom use, in an in-depth manner. Despite these limitations, this study is one of the first to explore the health needs and beliefs of FLMWs at the border of Thailand and Laos. As such, this study purposefully selected a heterogenous sample to characterize the experiences of female migrant workers as much as possible. Additionally, during the analysis process, the research team frequently reflected and discussed the interpretations and meaning of the results from various perspectives to ensure accuracy and reliability. This study utilized the help of a CAB who knew which, if any, individuals who would feel more comfortable talking about sensitive topics with researchers. Furthermore, this study utilized research assistants who had experience with this community to reduce the discomfort of discussing sensitive topics with strangers. Overall, this study is novel, timely and provides a baseline for future studies and for preventive interventions.

Future research should continue to investigate the health beliefs and experiences of female migrant workers. In particular, studies that examine specific sub-populations (i.e. sex workers, those who work in manufacturing, etc.…) to evaluate how and if specific subgroups experience or navigate health needs differently. Additionally, studies with larger sample sizes are needed to obtain a larger breadth of understanding. Other future research should also consider mental health assessments of female migrant workers to analyze how poverty, displacement, isolation, and other factors that are common to the migrant worker experience influence their overall health. Further contemporary research on migrant workers is needed everywhere, but especially in Southeast Asia where conflict in countries like Myanmar and Indonesia has been escalating.

Conclusion

The present study helped depict the health needs and beliefs of female migrant workers at the border or Thailand and Laos. We have highlighted a set of factors, specifically violence and lack of sexual and reproductive health knowledge, that shape the health needs of female migrant workers. The cultural acceptance of interpersonal violence and lack of general sexual and reproductive health knowledge created a perception of confinement and frustration among these women. Ideally, interventions to address the health needs of female migrant workers will empower them as well as educate them about relevant health and social services. However, in order to implement these interventions, other interventions must also be designed address upstream factors of culture and structural barriers (including documentation, and health insurance).

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