

Marginalization, Morbidity and Mortality: A Case Study of Myanmar Migrants in Ranong Province, Thailand

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Marginalizing conditions that migrants face in destination countries or during migratory processes have impacts on migrant morbidity and mortality. This study explores marginalizing conditions contributing to migrant death in Ranong Province, Thailand. Qualitative in-depth interviews with 60 key informants and non-participant observations of working and living conditions were conducted among Burman ethnic group migrants from Myanmar residing in Ranong Province.

The results of our study show that migrants face 1) unsafe working conditions, including limited access to proper protective equipment, not being informed of the availability of protective equipment, and a lack of knowledge about hazardous events; 2) limited access to health services, social security and workman's compensation funds; 3) negative attitudes and xenophobia toward migrants by the local population; and 4) limited access to legal protection. These factors put migrants from Myanmar at risk of marginalization, morbidity and even death.

Recommendations based on these findings include improvement of migrant workplace safety standards; greater accessibility to health services, social security and workman's compensation funds; better access to legal protection for relatives of deceased migrants; encouragement of corporate social responsibility among employers, including respect for the basic rights of migrants; and recognition of the significance of

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migrant contributions to the Thai economy. These measures would alleviate the marginalization of migrants and reduce mortality.

Keywords: *Marginalization, mortality, migrant, Burmese, Thailand, Myanmar*

Introduction

Migrants from Myanmar have been coming to Thailand for many years. Previously, the Thai government promulgated a number of regulations to allow professional workers to enter and work in Thailand to overcome labor shortages (Chalamwong, 2004). However, after Myanmar's political crisis in 1988, an increased flow of low-skilled labor migrants from Myanmar entered Thailand to seek better jobs and remit funds to their families at their point of origin. During 1992-1998, the Thai government restricted migrants to work in specific sectors and locations, e.g., fisheries, agriculture, construction, mining, transportation, manufacturing and domestic work in border provinces (Chantavanich, 2007). However, after the Alien Employment Act B.E. 2551⁴ was enacted in 2008, migrants were allowed to work in the two categories of laborers and domestic workers in diverse sectors. The list of allowed occupations was later expanded to include 27 occupations (Archavanitkul & Vajanasar, 2009). Currently, even though migrants are allowed to work in almost every sector, some of those who work in high-risk sectors are still facing marginalizing conditions, and this intensifies their risk of morbidity and mortality.

Sciortino and Punpuing (2009) estimated that migrants contributed around two billion US dollars or 1.25% of the total USD \$177 billion gross domestic product in Thailand in 2005. The Thai government has also tried to protect migrants' rights by upgrading the status of undocumented migrants to become documented migrants through a migrant registration process. Documented migrants who have been registered with the Ministry of Interior were given legal status through nationality verification from the authorities in their home countries. Those who pass the nationality verification process are able to work legally and receive social benefits similar to Thais (Department of International Organizations, 2010). However, in practice, there are still numerous problems in accessing these benefits.

Recent cases of migrant deaths in Thailand show that migrants are still facing unsafe conditions during the migratory process and when living and working in Thailand. Some of the more publicized cases include the discovery of dead migrants from Myanmar in a farm in Petchaburi Province in 2012 (Bangkok Post, 2012a); the death of two migrants due to heat and overcrowding in a truck during deportation in 2012 (Mekong Migration Network, 2012a); the deaths of migrants from Myanmar from a landslide during stone excavation in Petchaburi Province in 2013 (Grassroots Human Rights Education and Development, 2013); the discovery of the bodies of twelve migrants from Myanmar whose boat sank in the Andaman Sea, west of Ranong Province in 2013 (Myanmar Today News, 2013); and the shooting deaths of 15 unarmed Rohingya migrants by the Thai military in 2013 (Saiyasombut, 2013). In addition, road traffic and work-related accidents, injuries, murders, disappearances and suicides periodically occur to migrants each year (Yang, 2011).

⁴ B.E. refers to Buddhist Era, the calendar used by Thailand and other Southeast Asian countries.

Beside the above events, the study of Swaddiwudhipong, Ngamsaithong, Peanumlom, and Sriwan (2008) showed that after applying community active case surveillance, 93% of migrants were found to be infected by cholera, although no one died from the outbreak in Mea Sot District, Tak Province in 2007. Among those infected by cholera, almost 84% were migrants from Myanmar and the rest were local Thais. Sa-Nguanmoo et al., (2010) also found a high prevalence of hepatitis B virus (HBV) infection (around 7 to 11%) among migrant workers from Myanmar, Laos, and Cambodia. Tomita et al. (2010) found 28.5% prevalence of low back pain (LBP) among migrants, caused by poor health status, a history of back injury, twisting posture at work, and slipping on wet floors.

When morbidity worsens, migrants' mortality may also increase due to various reasons. Isarabhakdi (2004) highlighted how a number of migrants face difficulties in accessing health services due to their illegal status, financial constraints and language barriers. Additionally, health-seeking behavior of migrants is also influenced by their health beliefs, e.g., belief in spirits or the use of traditional (herbal) medicines.

The Office of the High Commissioner for Human Rights (2008) also argued that migrants face difficulties accessing vocational training, especially for work safety, and that they have limited freedom to join trade unions. Migrants, therefore, have less power to negotiate with their employers in case of morbidity or mortality due to work-related accidents or injuries. Srithamrongsawat, Wisessang, and Ratjaroenkhajorn (2009) also pointed out that access to accident and emergency services among migrants is somewhat contrary to the design of the universal health insurance coverage scheme. This is because migrants are only permitted to work and reside in the province in which they are registered. Therefore, access to emergency and accident services is limited to hospitals within the registered province and dependent on the terms and conditions created by each province.

All of these examples indicate that the marginalizing conditions that migrants face in Thailand can degrade their health to the point of death. This study therefore explores the marginalizing conditions increasing the risk of death for migrants from Myanmar in Ranong Province, located on the southwest coast of Thailand. Ranong was selected as the study area because it has a high case-fatality rate among migrants from Myanmar when compared to other provinces. Information gained from this study will encourage employers, health service providers and policy makers to better understand and foster programs, plans and policy initiatives that can lessen marginalizing conditions associated with migrant deaths.

This paper consists of five main parts. The first part describes the rationale for conducting the study. The second and the third parts present the conceptual framework and methodology applied in this study. The fourth part illustrates findings including the migration situation and marginalized conditions contributing to the death of migrants from Myanmar in Ranong Province. The last part elaborates on the discussion and provides recommendation based on the findings of this study.

Conceptual Framework

This study applies the concept of marginalization to understand how marginalizing conditions contribute to migrant's morbidity and mortality. Mullaly (2007) defined the term "marginalization" as "*a social process of becoming or being made marginal*" (p. 252-286). Young (2000) illustrated that it is "*an exclusion from meaningful participation in society, partly because the labor market does not or cannot accommodate them. Thus it becomes one of the most dangerous forms of oppression*" (p.35-49). Anupkumar (2007) elaborated that marginalization is "*overt actions or tendencies of human societies whereby those perceived as being without desirability or function are removed or excluded from the system of protection and integration, so limiting their opportunities and means for survival*" (p.3). However, this study defines the term "marginalization" as a process by which an individual or community or groups of migrants are oppressed, exploited or discriminated against by individuals, the community or social structure in Thai society, increasing vulnerability to morbidity and mortality. Marginalization limits migrants' access to economic, social, health service, political and cultural negotiation power.

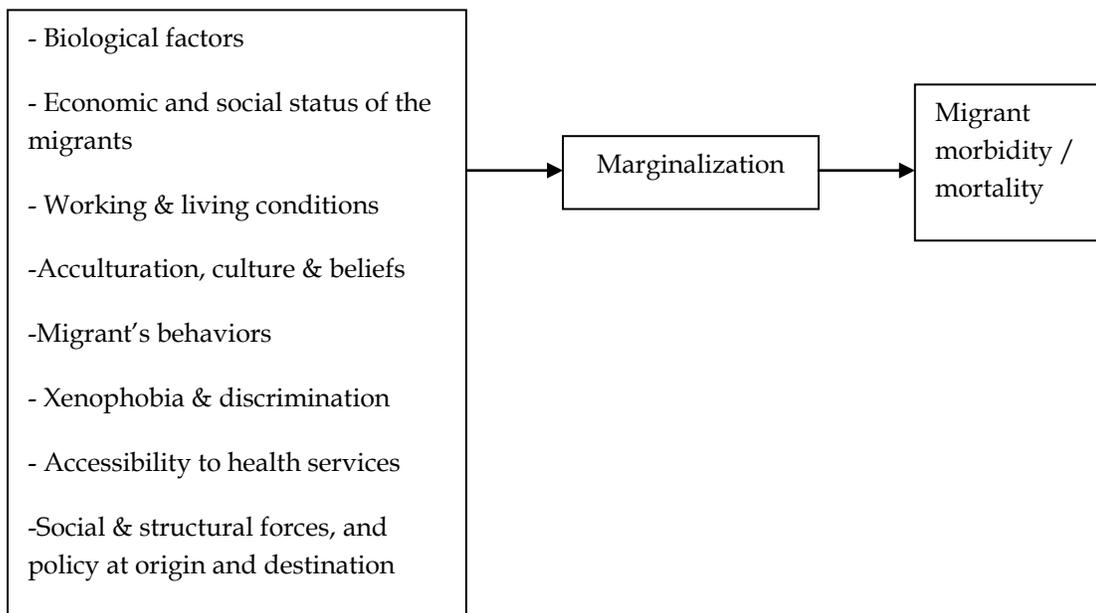
Daniel and Linder (2002) applied the concept of marginalization to enhance understanding of the causes of ill health. They argued that ill health is not simply a problem of the population, but that other important forces—including social inequality, conflict of social interest among different groups, an unfair distribution of power, property, information, production pattern and consumption—contribute to a population's health status. Moreover, the social process by which individuals' and groups' beliefs and feelings about themselves and their place in society can create a sense of marginalization and adversely influence the health of the people. Nevertheless, individual or groups' distance from the center of society -- which limits their access to housing, employment and education -- can make the marginalized group and the mainstream groups experience diseases differently.

When applying this concept to better understand mortality among migrants from Myanmar in Ranong, a number of studies have shown that there are various factors that contribute to the marginalizing conditions that affect migrant mortality. Studies undertaken by Fennelly (2007) among foreign-born immigrants and U.S.-born residents in the USA., and the studies of Kibele, Rembrandt, and Shkolnikov (2008) in Germany summarize research showing that poverty, low socio-economic status, living in substandard housing, not having access to medical care, adoption of an American diet, smoking, substance abuse and psychological stress can create health problems for immigrants. Noh and Kaspar (2007) highlighted that, among adult Korean immigrants in Canada, acculturation influences health advantages or disadvantages of immigrants. Poor health behavior and lifestyles, lack of resources and social networks, inability to pursue past cultural practices and lack of employment opportunities in their occupational field can affect immigrant health.

In the case of Asian countries, Banico (2010) reported that more than 700 female migrants from the Philippines die each year as a result of mistreatment by their employers. These migrants work in harsh and risky working environments without adequate protection, suffer from sexual harassment and poor living conditions, and work without overtime payment. Violent deaths, sexual abuse, torture, detention, mental breakdown, family separation, abandonment and unlawful youth behaviors among migrants and their accompanying dependents have risen dramatically.

These findings from the literature illustrate that there are various factors that can directly or indirectly intensify marginalizing conditions that can affect migrant morbidity and mortality. These factors include biological factors, economic and social status of the migrants, working and living conditions, acculturation, culture, beliefs and behavior of the migrants, xenophobia and discrimination, accessibility to health services, and social and structural forces or policy at the origin and destination countries.

Figure 1: Conceptual framework of factors contributing to marginalization affecting migrant morbidity and mortality in Thailand



Methods

Qualitative in-depth interviews (IDIs) with 60 key informants involved with the deaths of migrants from Myanmar in Ranong Province were conducted to characterize marginalizing conditions contributing to migrant morbidity and mortality. A list of the deceased migrants and their relatives residing in Ranong was compiled by local NGO staff and local residents working directly with the migrants. Snowball sampling was used to identify deceased migrants and their relatives. Other stakeholders involved with the death of the migrants were also identified through snowball sampling. The IDIs were conducted at a place where the migrants' relatives felt comfortable to share their experiences, such as at the migrant's house, a private room in the NGO office, school, or quiet places in their communities. Since the principal researcher had limitations in understanding the Myanmar language, a bilingual migrant helped translate during the interviews. Triangulation by interviewing various groups of stakeholders also was performed to investigate the reliability of the data. The groups of key informants and stakeholders are listed in Table 1.

The key informants and stakeholders interviewed gave informed consent before IDI were conducted. Qualitative data from the interviews was processed by recording, transcription and content analysis. The themes of the content analysis mainly focus on marginalizing conditions contributing to vulnerability for migrant death.

Table 1: Type and number of key informants who participated in the in-depth interviews

Type of Key Informant	Male	Female	Total
Relatives of deceased migrants	4	6	10
Migrant employers	5	5	10
Religious leaders (Buddhist, Christian, and Muslim)	6	0	6
NGO officers and health providers	4	2	6
Government officers ⁵	11	5	16
Others (community leaders, local residents, lawyers, Thai and Myanmar teachers, morticians)	9	3	12
Total	39	21	60

This study also used non-participant observation to observe working and living conditions of migrants in Ranong. The principal researcher spent around nine months observing and collecting information in Ranong during June 2009 - February 2010. Most of the migrants lived and worked in very crowded places with poor and unhygienic conditions. The observations noted were used to describe marginalizing conditions that migrants faced while working, living and sometimes dying in Ranong. Finally, secondary data from the Ranong Provincial Health Office and Police Department were also obtained. These data include official statistics on number of migrants who were sick and who died in Ranong.

The study has some limitations. Since support from a Burmese interpreter was needed to help translate information during in-depth interviews, some of the results in this study may be affected by inaccuracies in translation. In addition, since the principal researcher spent limited time in the study areas and observed the situation as a non-participant observer or outsider, the interpretation of these results mainly came from the point of view of the researcher based on the information from in-depth interviews and observation.

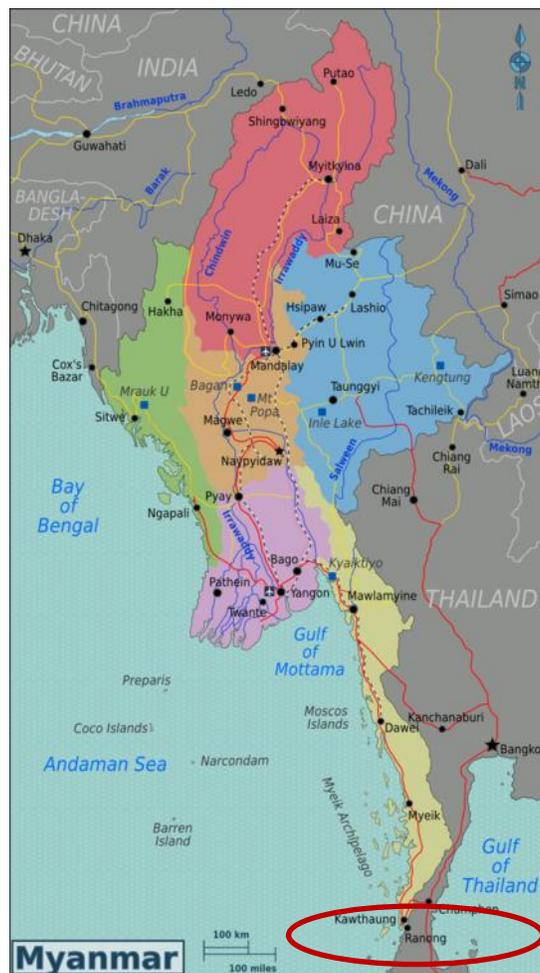
Study Area

Ranong Province is a border province located on the southwest coast of Thailand. It has more than 100 kilometers of border area adjacent to Kawthaung Province which is a busy border trade city on the southeast coast of Myanmar. Ranong was selected as a study area because it

⁵ Government officers included provincial health providers, district officers, labor protection officers, labor employment officers, social workers, social security officers (provincial and hospital), immigration police, policemen, military and national security officers, and provincial protection officers.

has a high case-fatality rate among migrants from Myanmar. In 2006, the case-fatality rate due to infectious diseases and external causes which include intended and unintended injuries among migrants from Myanmar in Ranong Province was 0.13 per 100 population while the case-fatality rate among Thais due to these causes was 0.07 per 100 population (Department of Disease Control, 2006). Major causes of morbidity found among Thais are diarrhea, malaria, chicken pox, conjunctivitis and pyrexias of unknown origins, while the major causes of morbidity among migrants from Myanmar are malaria, diarrhea, cholera, HIV/AIDS and STIs. The case-fatality rates due to HIV/AIDS and cholera among Thais and migrants from Myanmar are 1.02 and 2.30 per 100 population and 7.25 and 15.00 per 100 population respectively (Ranong Provincial Public Health Office, 2011) Nevertheless, Ranong is one of the top ten provinces in terms of the number of migrants from Myanmar who die while working in Thailand (in addition to Tak and Chiang Rai). Ranong is also one of the main transit and entry points for migrants, traffickers and smugglers who transport new-entry migrants to inner provinces or to other countries such as Malaysia, Indonesia and Singapore (Danish Immigration Service, 2011).

Figure 2: Map of Ranong Province and Kawthaung City



Source: Perry-Castañeda Library Map Collection, as found on Wikitravel-The Free Travel Guide (2014)

Migration Situation in Ranong Province

Migration from Myanmar to Ranong has occurred for many years due to long-term cross-border trade between Thailand and Myanmar. Interviews revealed that the majority of migrants from Myanmar to Ranong come from Kawthaung, Dawei, Myeik, and Palaw in the Thaninthayi Division and from Mawlamyaing, Paung and Moke Ta Ma in Mon State. Most of these states are located on the southeast coast of Myanmar opposite Ranong. Migrants from Myanmar can easily cross the border to Ranong via the Kraburi River and Andaman Sea by boat or by walking through mountainous terrain. Due to the high volume of cross-border trade and migration, Ranong has become a permanent immigration check point in Thailand (in addition to Tak and Chiang Rai Provinces).

The Ranong Provincial Police Department (2009) estimated that there were 47,875 documented and undocumented migrants from Myanmar residing in Ranong in 2009. This number has increased every year due to labor shortages and the increasing demand for low-skilled labor in Thailand. In 2011, the Ranong Provincial Public Health Office (2011) reported that the number of registered migrants in Ranong has increased dramatically. Around 74,911 migrants had health check-ups, and the number of migrant dependents had risen to 140,152 persons because most workers migrated with dependents. Among these numbers, there are more male migrants than female migrants. Two-thirds of these migrants are of labor-force age while the rest are children.

The majority of these migrants perform hard manual labor in settings such as construction, rubber and cashew nut plantations, pig and other animal farms, or domestic work, with the remainder in the fisheries sector (Ranong Provincial Public Health Office, 2009).

Currently, the number of migrants passing nationality verification in Ranong Province increased from 16 in 2009 to 50,924 in December 2013 (Department of Alien Administration, 2013). However, there are still a significant number of undocumented migrants who have not entered the nationality verification process and are still undocumented immigrants.

Marginalization Factors Contributing to Migrant Death

1) Unsafe working conditions, limited access to protective equipment, or lack of information about workplace risks

As mentioned above, a number of migrants in Ranong work as seafarers on fishing boats or in labor-intensive sectors such as lumber and grinding factories, construction, or agriculture. The results from qualitative analysis clearly show that a number of fatal accidents occur among migrants while on the job, as the following key informant noted:

There is a case of a migrant who worked on a fishing boat who died when his body was caught in the anchor rope during anchoring. The strength and speed of the descending rope cut the migrant's body in half. (Migrant relative ID1).

This case clearly reflects that provision for occupational safety on fishing boats to prevent migrants from fatal accidents is still inadequate. In addition to this case, some migrants have also died when hit by boats' hauling equipment, by drowning when their boat sinks or when accidentally being dragged into the water by a tug rope (Migrant relative IDI). Even though these kinds of accidents can also happen among Thai fishing boat crew, migrants are more vulnerable since most of them are unregistered, i.e., the employers hire them temporarily on a job-by-job basis (Employer IDI). Due to their temporary position, these migrants are not entitled to receive medical services as are the registered migrants and Thais.

In addition, there are a number of cases showing that migrants and employers still lack knowledge about hazardous circumstances or occupational hazards. There are a number of fishing boat crew members from Myanmar who have died due to exposure to hydrogen-sulfur gas poisoning on the fishing boats in Ranong, as one key informant reported:

Normally when fishing boats go out to the sea for several months, the fishermen keep their fish in confined containers. After keeping these fish in the containers for a long time, the fish can emit hydrogen-sulfur poison gas which can cause unconsciousness, kidney failure and death. When migrants go to pick up the fish from the containers without taking precautions, they can be exposed to this poisonous gas through inhalation (Health provider IDI).

Currently, most Thais working in the fisheries sector are boat owners and fish merchants rather than fishing boat crew. Migrants, therefore, have more chance of exposure to this kind of gas poisoning than Thais (Employer IDI; NGO health provider IDI). Government interventions to provide education about fishing dangers for both fishing boat owners and migrant seafarers is still lacking and needs to be enhanced. However, very little funding has been provided to prevent migrant deaths from accidents and occupational health hazards. Most of the budget is pooled to prevent infectious diseases among migrants (NGO health provider IDI).

Besides fatal accidents on fishing boats, some migrants also have major and minor injuries from working with machines in factories. An example is power saw accidents which have resulted in severed fingers, arms, legs of migrants working in lumber and grinding factories. Some also die from falls at construction sites (Employer IDI; Migrant Relative IDI). One of the migrants whose hand was injured during work in a wooden box-making factory explained:

My duty was to cut wood into small pieces. I did not know that my hand was cut by the saw until my friend told me. It seems like I was not mindful at that time (Migrant IDI).

This accident reflects that migrants work in unsafe working conditions without adequate protective equipment. Even though the Labour Protection Law requires that every workplace must provide protective equipment to protect employees from hazardous circumstances, a number of migrants still face severe and fatal accidents during work due to limited access to or being uninformed of protective equipment use or precautionary strategies during work. Even though employers in some workplaces have already shown concern and have provided protective equipment in the workplace for migrants, some of the migrants still do not know how to use this equipment due to language barriers. Therefore, migrants lose their lives or limbs, or become disabled due to these areas of ignorance (Labor officer IDI). According to the Workman's Compensation Act B.E. 2537 (1994), Thai laborers are eligible to receive 60% of their

monthly wages for the loss of certain organs for a period of time not exceeding ten years (Social Security Office, 2007). However, very few migrants are able to receive this compensation because they do not know how to negotiate with their employers.

2) Limited access to health services, social security and workman's compensation funds

2.1 Limited access to health services

Limited access to health services can lead migrants who face potentially fatal accidents, occupational hazards or serious illness to be exposed to higher risks of death. In the case of minor injuries, local NGO clinics supported by international organizations are often able to provide treatment to the migrants. However, for major injuries which require surgery, the providers at NGO clinics will refer migrants to the local hospital, often resulting in delayed treatment. As the following key informant explained:

Sometimes if the patient has a serious injury, the hospital cannot say "no" to the patient because the injury is a threat to the patient's life. However, for medium and minor injuries, these become a big problem because the hospital knows that the patient is not likely to die due to these injuries. So they ask us to refer the patients to other places. Sometimes I must refer patients to many hospitals before one will accept them. Finally, some refer the patient back to me again. It happens like this again and again (NGO health provider IDI).

Even though migrants holding health insurance cards who experience serious accidents are able to access medical treatment at facilities where they are registered, undocumented migrants who do not have health insurance or work permits still face problems. Employers intermittently pay hospital fees for their employees. However, they have been known to neglect to pay compensation (NGO staff IDI). Most of the undocumented migrants who do not have health insurance or work permits also cannot afford surgery or other health care costs (NGO staff IDI).

Changing the migrant registration policy from an area-based, non-quota system to a quota-based system also indirectly limits migrants' and their dependents' access to health services. One of the provincial health officers explained:

It is difficult to continuously provide health promotion and prevention programs and health services to the migrants since the number of registered migrants who apply for the health insurance each year varies depending on migration registration policy. Some years the government allows the migrants' dependents to register. However, in some years they do not allow them to stay, and intend to repatriate them. If they do not allow newly arriving migrants or those who have not been registered to register in later years, the number of migrants applying for the health insurance scheme will gradually drop. The reduced number of registered migrants will affect the budget for migrant health insurance and migrant health expenditure (Health providers IDI).

In the past only those who have health insurance and work permits could enjoy the benefits of the migrant health insurance scheme. Only migrants who need to extend their work permits

and health insurance cards will come back to have physical check-ups and extend their health insurance cards for another year. (Health provider IDI). Therefore, this indirectly affects the amount of resources in the migrant health insurance fund which is available to hospitals, and which will rise or fall depending on the number of migrants that apply for health insurance while the health expenditure for migrants continues to increase. This situation indirectly affects migrants' health; hospitals have a limited budget to cover health care costs of the migrants who request hospital fee exemption as well as to support health promotion and prevention among migrants. As a result, undocumented migrants who cannot afford health care costs of hospitals and health insurance will have limited opportunities to get services (Health provider IDI) A long-term migration registration policy that takes into account undocumented migrants' access to health services through health insurance should be further developed.

2.2 Limited access to social security and workman's compensation funds

Normally, in the case of death and disability of workers, the Social Security Service and the Workman's Compensation Act B.E. 2537 (1994) provides welfare and benefits for workers whose employers pay contributions to the social security and compensation funds, as well as to employees paying their counterpart contributions. The coverage is divided into seven types: sickness, maternity, disability, death, child allowance, old age and unemployment. As long as wages are paid, employers are duty bound to submit their contribution to the Social Security Office within 15 days in the month following the month when the contribution is deducted. Registered migrants who have work permits, and who pass nationality verification according to the ministerial regulation of February 13, 2012, are protected under these Acts. However, undocumented migrants who become sick or die due to causes related to their work are still not covered by these Acts (Social Security Office, 2007).

In practice, there are a number of migrants and even Thai employees who are not hired under contract and who are unable to access social security and workman's compensation funds. One key informant cited this example:

In the case that we need to go out to sea for 20 days, the head of the migrants from Myanmar will gather around 20 migrants to work as the fishing boat crew for us. We would pay a total of 160,000 baht to the head of the migrants. The head of the migrants manages this money for food and salary for these migrants. We hire them based on the number of working days rather than hiring them under contract. (Employer IDI)

Migrants or Thais who work as day laborers, e.g., fishing boat crew, construction workers or migrants who peel squid and shrimp, are paid either based on the number days that they work or by the unit—i.e., the weight and quantity of squid and shrimp peeled each day. Thus they are hired on a job-by-job basis rather than under an employer-employee contract. They are not entitled to receive benefits from the Social Security Office or from the Workmen's Compensation fund if they get sick or suffer disability or death from their work (Social security officer IDI; Migrant relative IDIs). However, Thais are in a better position since they can access health services through the 30-baht health insurance scheme while migrants cannot. Even the registered migrant whose hand was cut off by a power saw at work also faced problems accessing this fund, as she explains below:

After my hand was cut off by the power saw, the wood factory owner took me to the hospital. I had to stay there for 22 days. The factory owner was responsible for paying for my medical treatment, but I did not get any compensation for my injury from him. However, he allowed me to stay here further. After my hand was cut off, my income declined to almost nothing since I could not work as much as I did before the accident (Migrant IDI).

This case reflects that even though the factory owner paid for her medical treatment, the migrant did not get compensation for the loss of her hand or compensation for the loss of her working ability from the accident. This is because her employer did not apply for social security and the compensation fund for her (Migrant IDI).

Even though, in principle, migrants who pass the nationality verification process will receive benefits from social security and the workman's compensation fund just as Thais do, the acceleration of the process to provide coverage to more than 826,868 migrants in 2012 did not adequately increase access to better social and health services. Only 281,316 migrants have accessed these funds in 2013, since the majority of their employers still do not pay their contribution to the Fund. Thus, migrants who already passed the nationality verification still face obstacles in accessing these benefits. Efforts to provide registered migrants with access to these funds should be accelerated. Moreover, there is no standard practice which regulates the compensation for the illness or death of undocumented migrants caused by their working conditions (Employer IDI; NGO officer IDI).

3) Negative attitudes toward migrants

Negative attitudes and behavior of local residents toward migrants can also affect migrant health. Even though Ranong has a long history of border trade with Myanmar, some of the local people in this province still have a sense of "xenophobia" regarding foreign migrants. Still, these attitudes are not as severe as in Singapore or some countries in Europe, where migrants are excluded or discriminated against in terms of employment opportunities (European Union Agency for Fundamental Rights, 2011; Gaydazhieva, 2013; Comrie, 2013). This might be due to the fact that migrants from Myanmar have been living and working in Ranong Province for many years in response to the labor shortages in some sectors. Most of these migrants are economic migrants who migrated for work and sought better opportunities in their life. The majority of the migrants do not pose a threat to the local residents and just try to work hard in order to earn their living. Migrants also support Ranong's economy. Local residents see that it brings mutual benefits when local residents, employers and migrants work together (Local residents IDI; Employer IDI).

However, negative attitudes or xenophobia among some groups of people can become a threat to migrant life. Some of the national security protection officers and local residents view migrants from Myanmar as a threat to national security, and to economic and social development of the country. They argue that:

- 1) Ethnic minority migrants from Myanmar use Ranong Province as a base to counter and negotiate with the Myanmar government, which might affect international relations between the two countries (Military officer, IDI).

2) The low wages of these migrants can increase unemployment of Thais. Hiring cheap labor can distort wage rates and deter Thais from entering the labor market (Local resident IDI).

3) Conflicts and quarrels among the migrants themselves can become violent, threatening life and property of local people in the area. Since Thais feel unsafe about their life and property while living near the migrants, some try to segregate themselves from them (Local resident, IDI).

4) Unhygienic living conditions of migrants can cause epidemics of diarrhea, malaria, HIV/AIDS and elephantiasis (Health provider IDI).

5) Crimes, drug addiction, and drug dealing among migrants can become a threat to national security since migrants can easily flee to Myanmar after committing crimes in Thailand. It is, therefore, difficult to control these problems (Policemen IDI).

6) Increasing the number of migrants can intensify the increasing number of stateless children which will result in competition for infrastructure use with Thai citizens, such as public health and educational services. (Teacher IDI, Employers IDI)

These negative attitudes, xenophobia and discrimination can lead to incidents of violence against migrants. Some of the deceased migrants' relatives stated that they had been attacked by local teenagers due to xenophobia:

I'm really afraid of local teenagers. Every day, they always ride very loud motorcycles near our houses. My daughter works in a factory on the night shift. One day when she came back home at night, these teenagers rode their motorcycle directly at her and hit her chest with a big iron chain and ran away. She got seriously injured. We took her to the hospital but we couldn't inform the police regarding this event because we were afraid of retaliation by these youth (Migrant IDI)

Many migrant victims of violence have to tolerate these conditions and do not seek justice since they are subordinated by beliefs that that they are not "Thai", and have illegally crossed the border to live in Thailand.

4. Limited access to legal protection

Generally, migrant workers who are lawfully registered to work in Thailand are entitled to the same rights as Thai workers in accordance with the Labour Protection Act B.E. 2551 (2008). These rights include minimum wages equal to that for Thai labor, holidays, sick leave from work, overtime payment, prohibition of work on holidays and prohibition of dangerous work unless permitted by law. The rights also include maternity leave and provision for filing complaints against employers and support for taking such disputes to the courts (Department of International Organizations, 2010).

The Criminal and Civil Codes benefit migrant workers whether or not they enter the country legally and whether or not they are undocumented. Qualitative study results revealed that, in practice, migrants are still facing problems in terms of legal protection. The majority of migrant death cases due to occupational hazards and accidents or murder cases have been rarely prosecuted in court. For instance, a female domestic worker was raped by her employer, who tried to kill her afterward. One of the migrants explains:

This woman had just worked for the Thai employer for 3-4 days. This employer likes to watch pornography and asked her to watch pornographic movies with him. After seeing the movies, the employer tried to persuade the worker to have sex with him. However, she resisted. He then raped and tried to kill her. The employer thought that the migrant had already died. So he dumped her body in the rubber plantation garden. However the woman was still alive and a couple of Kareni migrants found her and got her help so she survived. (Migrant IDI)

This case reflects that female migrant domestic workers are vulnerable to sexual harassment and exploitation by Thai employers because they are normally restricted to the inside of the house. Some of them do not have work permits. Therefore, they are afraid of being arrested by the police if they file suit in court. One of the key informants elaborated:

There are very few cases where a deceased migrant's relatives or friends dare to be witnesses through suits in court in order to get compensation or press for legal prosecution for deceased migrants since they are afraid of arrest and deportation. Normally, according to the forensic law, all unnatural death cases such as murder, suicide or accidents must be investigated. However, if there was no prosecutor or the death did not happen due to crime, there is no need to conduct an investigation (Police officer IDI).

This statement reflects that there are very few cases where migrants continue to pursue a fair trial to call for a migrant's compensation from work-related injuries or death, or request prosecution for the perpetrators of crimes. In addition, migrants from Myanmar do not have surnames and Myanmar does not have a good civil registration system; thus documents to prove the families' right to make claims as a deceased migrants' relative are lacking. Thus, many of them face difficulties in continuing to trial (Lawyer IDI). Even though government-to-government collaboration to help facilitate fair trials for migrants was established, in practice, there are a number of migrant death cases that still have not reached a legal resolution.

Discussion

In the era of ASEAN integration, intra-regional migration of high-skilled labor to more prosperous countries in the region will increase (Stiftung, 2012). However, migration of low-skilled undocumented migrants is a growing challenge, because mechanisms to secure these workers' rights are not adequately in place (Mekong Migration Network, 2012b). Even though Thailand has a long history of in-migration from Myanmar, a large number of migrants residing in Ranong Province are still encountering unsafe working conditions. They become victims of exploitation and disempowerment due to social inequality. These migrants are limited to jobs in low-income sectors although it is their right request the legal minimum wage, equal to that of Thai labor. They also have little control over resources available to them. They lack capacity to participate politically, culturally, in markets or in the institutions to voice their needs. Some of them become stigmatized and are often blamed by negative public attitudes such as "un-Thai", "cheap labor", "aliens" or "others" and are seen as threats to national, economic and social security of Thais.

Even though there are a lot of Thais who also still work in dangerous conditions and are exposed to accidents, occupational hazards and other health issues, migrants are more

vulnerable since a large number of them work in higher-risk sectors with inadequate protection and welfare. Fear of arrest and detention and a lack of confidence in their status also discourages them from requesting better job opportunities, welfare, health services or protection for themselves.

Moreover, social, economic, political and legal structures in Thai society also have not been effectively implemented to protect the rights and benefits of the migrants. Migrant registration and migrant health policies in Thailand were initiated based on the concept of protection of the nation state, national security and prevention of epidemics that can affect the well-being and health of Thais. Under this concept, migrants are perceived as threats to national, economic and social security of Thailand. Processes to protect their rights or document their death, therefore, have been inadequately or improperly conducted. Even though the amnesty policy for migrants and the nationality verification process intends to enable migrants registering with the Ministry of Interior and Ministry of Labour to become legal immigrants, with better access to welfare and social protection through the social security and workman's compensation funds, the slow process of registration is delaying coverage of migrants by these funds.

The changing migrant registration policies that caused a decrease in the number of registered migrants also results in reduction of compulsory migrant health insurance financing sources, and subsequently causes a greater burden and dependence on out-of-pocket payment by the migrants themselves. It also results in a decreasing budget for hospital exemptions which increases the financial burden on the migrants and the hospitals, particularly in border areas (Srithamrongsawat et al., 2009). Because of these reasons, low-income, undocumented migrants have to cover their own health care costs and face difficulties accessing health services. All of these circumstances highlight the fact that mechanisms to reduce and prevent migrants' marginalization, which we have seen to be associated with mortality and morbidity risks, have been inadequately undertaken in Thailand. It is therefore necessary to enhance the capacity of all related organizations to initiate suitable strategies to alleviate the marginalization of migrants.

Recommendations

The marginalization that migrants face cannot be overcome by a single person or organization. This effort requires collaboration from various groups of stakeholders, drawn from the public and private sector in the countries of origin and destination. Since migrants are regularly excluded from meaningful participation and protection in Thai society due to subordination by social and structural forces which limit migrants access to social, health and legal services, their life and health is threatened. Moreover, the spread of negative attitudes toward migrants and conflict of interest between migrants and employers can cause migrants to become victims of violence and exploitation by local residents, employers, and local officials. In order to overcome these problems, reduction of social inequality and negative attitudes towards migrants through provision of universal access to social welfare and health services, improvement of social and structural processes that take into account the protection of migrants' rights, and the recognition of migrants as significant contributors to the Thai economy should be implemented. These structural changes will ensure that migrants can be better accepted and can access better welfare and protection by legal enforcement with support from the Thai people.

Moreover, government support by improving the migrant registration process that covers both documented and undocumented migrants and their dependents should be developed. Improvement of both documented and undocumented migrants' access to health services and social security and workman's compensation funds should be enhanced. Penalties for those who exploit migrants must be effectively enforced. Facilitation of effective government-to-government collaboration for fair trials for deceased migrants' relatives through countries of origin and destination should be empowered. Encouragement of corporate social responsibility among employers with respect to the basic rights of migrants, especially in terms of work safety and social welfare for migrants, should be promoted.

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