

## Part 2: FGD



## **Acknowledgements**

The Report on Focus Group Discussion Qualitative Data Collection is one of the outputs of the situational analysis on pandemic preparedness planning and response among selected migrants and village health support groups (VHSGs) in Svay Rieng, Cambodia. The situational analysis is part of IOM's Pandemic Preparedness for Migrants and Host Communities Project, which is implemented in close collaboration with government partners both at the national level and in Svay Rieng, partners from United Nations (UN) agencies and non-governmental organizations (NGOs), as well as with community leaders and migrants.

With technical guidance from IOM, data collection and information gathering were undertaken by the staff of three government project counterparts in Svay Rieng: the Department of Social Affairs, Veterans and Youth Rehabilitation (DSVY), the Department of Health (DOH) and Department of Labour and Vocational Training (DoLVT). A consultant designed the qualitative data collection tools in conjunction with IOM and trained the IOM Svay Rieng team to use them.

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## **Executive Summary**

The Focus Group Discussion qualitative data collection was conducted in selected areas in three border districts – Svay Teap District, Chantrea District and Kompong Ro District – of Svay Rieng Province, Cambodia. Both cross border migration and internal migration are common in these areas. The following four categories of key informants were selected and invited to participate in the FGDs: Cambodian returnees (irregular migrants) from Vietnam; garment factory workers and casino workers; Vietnamese migrant workers, who had been living in Svay Rieng for a few years and were engaged in trading goods; and Cambodian VHSGs.

The goals of the FGDs are:

- to provide a profile of migrants in selected Svay Rieng areas, including how they access health and social services; to provide information on the roles and responsibilities of the VHSGs, and to determine their knowledge of pandemic preparedness and response and attitudes towards it, as well as their level of preparedness or general feeling about their ability to cope with a pandemic or any other crisis; to provide information on how the capacities of migrants, host communities and VHSGs could be strengthened for pandemic or other emergency preparedness at the community level.
- to provide local authorities and key stakeholders, specifically the Provincial Committee for Disaster Management with baseline information and with the necessary tools to put together a more migrant-inclusive pandemic preparedness plan at the community level.

The FGD data collection team consisted of staff from both the health and non-health sectors, namely, DOH, DoLVT and DSVY. The staff from DOH are members of the provincial Rapid Response Team. Those from the DSVY work together with IOM on counter-trafficking activities, while the DoLVT staff liaise and coordinate with the casinos and garment factories in Svay Rieng.

The research team received two-step training, which involved a half-day training of trainers for IOM staff on FGD methodology and procedures, and the IOM FGD trainers training the designated moderators.

The FGDs were conducted with key migrant groups and VHSGs in order to assess their preparedness for pandemics and other emergencies. In total, ten FGDs were conducted, involving 20 Cambodian returnees, 21 factory workers, 20 casino workers, 20 village health support workers and 16 Vietnamese migrants.

## **Conclusions**

### **1. Vulnerability of migrant groups**

The FGDs indicate that Cambodian returnees, with their seasonal short-term work in Vietnam, are the most vulnerable migrant group for the following reasons:

As farmers by profession, their livelihoods can be directly affected by droughts and floods, insect plagues, storms and animal diseases. In the off-season when they are not working in the fields and have nothing to sell or eat from their land, they work as migrant workers in Vietnam, as well as in Phnom Penh. It was clear from the FGDs that this work was, however, a necessity to sustain their families, including putting food on the table.

Any unexpected expenses, such as those that result from illness, whether of a human, or of

animals (leading to the loss of animals), could lead to destitution. Migrant work seems to be a way to (a) provide one's family with some extra money and meet needs during the seasons when there was little income or food from farming available, and (b) try to respond to a financial crisis in a family. The absolute dependency of families on income from migrant work could, however, open the door to exploitation. The less regulated sectors, such as construction and farming (day labourers), seem to be more problematic, while the casinos and garment factories provided better situations for migrant workers.

From the FGDs, it was difficult to gauge the exact level of vulnerability faced by the Vietnamese migrants, but it did indicate that they also faced some of the issues faced by the other migrant groups. Some Vietnamese migrants worked as construction workers, which would indicate that perhaps their work was seasonal as well. The vegetable sellers and traders, however, seemed to be working in Cambodia because of the opportunity of lack of local vegetable sellers and traders, and they did not seem to feel as vulnerable as the Cambodian returnees did in Vietnam.

Both the casino workers and the factory workers stated that they usually send their earnings home and also spend them on self-expenses including living and other basic needs. They seemed to have relocated from villages that were not very far away, although this was not clear from the discussion responses.

Important to an understanding of vulnerability, however, are the level of education, family situation, gender and age of the different migrant groups. Almost all the casino workers were single and in their early to mid twenties with higher levels of education than the other migrant groups. They emphasized that they sent money home to their families and were seeking to

gain experiences and skills and to access more education while working. The factory workers were mainly in their mid to late twenties and married, causing them to have slightly greater responsibilities towards their immediate family as well as their parents/siblings. They indicated that the factory was close to their homes and that the environment was good.

The average age of the Vietnamese migrants was late forties to early fifties, and most had families, although there were some widows and widowers, and lower levels of education. The Cambodian returnees were a mix of ages, with the average in their early forties, the majority with either no education or a very low level of education, and families, leaving them perhaps vulnerable to exploitation as they seemed to be able to find jobs only in unregulated sectors. Age and life experience could mean a greater incidence of illness, and greater family responsibilities, which led to the need for a greater income. A lower level of education and possibly less spare time outside of work could lead to less access to information about pandemic preparedness measures and, as discussed in more detail below, could also prevent them from accessing health-care systems when unwell.

## **2. Barriers for migrant groups' health seeking behavior and access to health care**

All groups identified poor health and illness as potential hazards to their well-being and their families' livelihood due to the costs associated with seeking medical care and treatment. Casino and factory workers, Cambodian returnees go to health centers and tend to self-medicate as an initial response to ill health. Most migrants will seek medical services if they are seriously ill.

Cambodian returnees identified village or commune authorities if the needed assistance. Vietnamese migrants will likely go home and seek consultation at a Vietnamese hospital. Factory and casino workers may not readily go to seek services from local authorities or

service facilities. VHSG respondents also indicated that, for cultural reasons, patients often chose not to access assistance at health centres until they were seriously ill, preferring to try traditional remedies and prayer. In the discussion, the VHSG respondents seemed to be referring to the Cambodian host community, although it is likely that these observations are also pertinent to the Cambodian migrant populations. Both of these issues are potential barriers to pandemic preparedness as people tend not to seek treatment or notify the relevant authorities when they are ill.

Further barriers included poor roads, especially during the rainy season, the poor patient-doctor (health service provider) relationship and manners towards the patients (impolite, ignore patients) and the lack of medicines at health centres. These are systemic issues that further prevent patients from accessing health systems, reducing the likelihood that health systems can identify a potential disease outbreak. Recommendations by the migrant groups included having doctors available in villages and able to make home visits, medical staff always present at health centres, and good medicines available at the health centres. The Kampong Ro Cambodian returnee group did not make these criticisms, and seemed very happy with their health services. The reason for this could be an area for further investigation.

### **3. Gaps in migrant communities' knowledge of health topics**

The FGDs indicated that, of the migrant groups, the Cambodian returnees had received the most education on a broad range of health topics. The FGDs with VHSGs further showed the extensive educational work that they, along with the local authorities and health centres, conducted by disseminating health education information within their communities. In particular, there seemed to be a high level of understanding of avian influenza transmission and prevention measures among migrant groups and VHSGs. The knowledge of the

Cambodian returnees indicates that this work is successful, although the VHSG respondents felt that community members' knowledge could be improved on, particularly of pandemic preparedness. The FGDs with the Vietnamese migrants indicated that they had received education on health, such as exercising, and not drinking or smoking. However, they did not mention any further health messages. It is possible that this has to do with the limitations of the FGD (that is, insufficient probing) or, as would be expected, that they have less access to health education systems.

The majority of the migrant groups have access to media such as television, radio and personal contacts (friends and family), as well as the village or commune chiefs. Health education also came from NGOs, IOM, television, radio, posters, leaflets, company leaders, health staff and doctors. The Vietnamese migrants said that television and radio are their primary sources of information. Casino and factory workers have not mentioned health centers or village health staff as sources of health care and information which suggests that they are largely isolated or do not access the Department of Health system.

#### **4. Gaps in migrant communities' understanding of illness and transmission of illness**

In general, there seemed to be an awareness of the illnesses communities experience, but not of how they are transmitted (with the exception of avian influenza). The focus of the FGD questions was avian influenza, and all the migrants were able to describe prevention measures and to identify how it could be transmitted. It was not clear if they understood the link between healthy practices, such as hand washing, and how red-eye disease, typhoid and cholera are spread, or why some of these diseases are more prevalent during times of natural disaster. This again indicates that further education, based on research, targeting these groups could improve pandemic preparedness outcomes. All migrant groups stated that they would inform village and commune authorities and health staff if an outbreak occurred.

## **5. Non-pandemic emergency preparedness**

All migrant groups identified flood, drought and storms as emergency events they had experienced. The Cambodian government agencies and the Cambodian Red Cross were viewed as key actors in providing assistance and in addition, the World Food Programme, DSVY and the Catholic Relief Services. The VHSG respondents felt, however, that their assistance was not adequate. In terms of preparedness measures, the respondents had similar plans, including putting money aside, and having stored rice and other food, medicines and firewood. The factory workers also mentioned protection from mosquitoes, and keeping the house and compound clean. In the case of a disease outbreak, however, preparedness measures, as opposed to prevention measures, were not elaborated on by any group. The Vietnamese migrants had the fewest preparedness measures in place, although they were the only group to mention monitoring the media as a preparedness step.

In terms of infrastructure steps that would better prepare communities for disasters, raising houses on stilts and raising the land were identified and practiced by the migrants and VHSGs. They also identified problems with roads and services at health centres as obstacles to accessing health care. Therefore, road conditions, the preparedness of health clinic staff, including enough supplies of medicines, and enough staff and funds for village outreach, are issues to be looked into further.

The VHSG respondents faced potential planning obstacles, and cited difficulty in bringing people together for information sessions as the primary obstacle in doing their work. They further emphasized that, when disasters occurred, they felt that they had to be resourceful and find solutions themselves, by either looking for new creative solutions or using traditional practices, as government responses were often too slow or unable to respond to the problem

at all. This indicates a perceived and actual gap between the response planning and the capabilities of the external agencies and/or the government to meet the needs of the local people. In general, the VHSG respondents did not have a formal plan or preparedness measures in place and stated that it was difficult to have a preparedness plan when one did not know what was going to happen in advance. This indicates the need for further training for these key actors in preparedness and response delivery. The VHSG respondents demonstrated their solutions and response-orientated thinking as they began to explore the possibility of using existing village-based associations as a way to assist people.

## **6. Barriers to VHSGs working with migrant communities**

The VHSG respondents indicated that the transient nature of migrants led to their poorer health as they lived in more vulnerable conditions, which, from the voices of the migrants themselves, could be representative of situations the Vietnamese and internal Cambodian migrants face, and what the Cambodian returnees experience when working in Vietnam. The VHSG respondents also indicated that, if migrants became seriously ill, they would seek treatment in Vietnam (it is fairly common for Cambodians who have the ability, to seek medical treatment in Vietnam due to the perceived superior health system at a reasonable cost). It was not clear which specific migrant groups the VHSG respondents were speaking of, although all migrant groups, with the exception of the Vietnamese migrants, stated that the health centres were one place they would seek medical assistance. It was further stated that the option of seeking assistance at a hospital in Vietnam required money. The VHSG respondents seemed to say that they felt these migrant groups needed training on where they could access health-care services and when it was sensible for them to do so.

Based on VHSGs' responses, there is a need to develop more strategies to access migrant workers in order to assess their state of health, which could also be used as a training opportunity and could be one way to address barriers to accessing migrant groups. Strategies

proposed by VHSGs focused on educating the migrants' family members, who would in turn educate the migrants. A concern, however, is that the Vietnamese migrants and the casino workers did not indicate that they learned about health topics from family members. There was no discussion of whether there were any existing medical screening processes (except in background documents); for example, the factory workers refer to a factory doctor, but it is not clear if they are required to have a medical check-up before working at the factory, and if they did, if that information was shared with the Cambodian health authorities. It is also unclear if VHSGs or health centres have any plans or abilities to reach out to migrants, which might prove useful in improving migrants' access to health services and developing migrant inclusive pandemic preparedness planning and response.

## **Recommendations**

1. Undertake FGDs with Cambodian migrants<sup>1</sup> in Vietnam when they are doing seasonal work, and run similar FGDs with the Vietnamese local authority and health workers. Discussion points could include how the Vietnamese village-level health-care workers at hospitals feel about Cambodians seeking treatment there (both migrant and non-migrant), and what systems and practices are in place and could be improved to better (a) survey health issues, (b) identify and respond to potential outbreaks, (c) develop prevention actions that target both Cambodian medical visitors and migrant workers accessing Vietnamese health systems and engaging in trade activities that could spread diseases, and (d) improve the access of the vulnerable Cambodian migrant workers to these systems.

Further research could also include FGDs with Vietnamese returnees in Vietnam in order to better gauge the reasons they work as traders or travel to Cambodia as day labourers for other

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<sup>1</sup> In December 2008, IOM conducted an FGD and a KAPB survey in Tay Ninh in collaboration with government partners. The results of both the Svay Rieng and the Tay Ninh situation analyses will be shared with Cambodian and Vietnamese government counterparts and other stakeholders.

types of work. This would help in better understanding their level of vulnerability, and which Vietnamese systems they access to learn about preparedness measures and health education topics.

2. Ensure that both a gender and an ageing analysis of the future work of the Project is incorporated into all aspects of programming. This would lead to gender- and age-appropriate planning and consultative processes, and activities and strategies that capture (a) how knowledge and information is gained by women and men, youths and the elderly, (b) their respective roles in prevention measures, (c) their respective roles in preparation planning, (d) their respective risks and vulnerabilities to illness and in emergencies, and (e) the responsibilities of women, men, youth and elderly in emergencies both in the family and in their communities.

3. Design strategic approaches to disseminate information appropriate to the age, gender, workplace, culture and language of the migrants in order to raise their awareness and to stress the importance of pandemic preparedness planning and response.

4. Conduct further training for migrant groups on prevention measures and how pandemic preparedness planning can mitigate their impact.

5. Address priority infrastructure and multi-system issues that would have an important impact on the well-being of migrant communities in times of emergency. Key areas identified by migrant groups are as follows: (a) having better public health system functioning, including medicines available at health centres/clinics, and increasing the number of health-care staff and the quality of patient care; (b) improving roads and (c) improving houses so

that they are raised above water levels.

6. Continue to inform migrant groups about the services offered at health centres. A question is whether migrants are able to access free health services, particularly Vietnamese migrants as Vietnamese nationals in Cambodia, and Cambodian migrants in Vietnam.

7. Look at the role of private health-care clinics/hospitals and how to incorporate these providers into pandemic preparedness planning. Conduct an FGD with private health-care providers similar to the one conducted with VHSGs, based on information that migrants also access health care at private health clinics/hospitals.

8. Conduct further research into actual planning processes in place in migrant communities in order to determine if their preparedness measures are part of annual planning and/or are put into action only after an indication that there may be a possible disaster. Further explore (a) whether current planning would meet the needs of the community after a range of disaster situations and (b) how external agencies could best support and supplement these plans.

9. Identify ways to integrate traditional health practices into pandemic preparedness plans and to link the traditional healers and religious leaders through training and their participation in formal planning structures into preparedness planning and response activities.

10. Develop strategies to better enable VHSG members to bring together village members and migrant groups and thus to plan for and develop pandemic preparedness measures. The VHSG respondents proposed having snacks as an incentive to encourage them to attend; however, within the scope of preparedness steps it is likely that other incentives can be found to encourage migrants to engage in these steps.

11. Strengthen the health sector's ability to respond to VHSG requests for assistance so that they feel they are receiving the support they need to do their work, and improve communication channels in both directions. Identify in greater detail which common requests from the VHSG need responses from the health centre, and identify the health centre's requests of area health officials, and the reasons for the delay in response.

12. Build on the experience and information gained during the FGDs, which gave the migrant communities a forum to contribute to the development of pandemic preparedness strategies. This can be done by identifying other targeted ways migrant representatives (both women and men) can continue to participate in and, when appropriate, take the lead in the process of planning these strategies.

13. Further develop existing strategies (for example, IOM returnee health assessments) to map and respond to the health status of migrant communities.

14. Conduct further training with VHSG members in preparedness and response delivery, addressing the purpose for pandemic and non-pandemic emergency planning. Further explore with these key actors, as well as with village and commune chiefs (those who are not members of VHSGs), other key local authorities, representatives of migrants and local villagers (including men, women, youth and the elderly), traditional healers and monks, what structures currently exist within villages and migrant community groups that could be harnessed to develop better preparedness and prevention measures. The VHSG respondents demonstrated their solutions and response-orientated thinking as they began to explore the possibility of using existing village-based associations as a way to assist people.

15. It would be worthwhile to know what the responsibility of factory and casino managers is towards their migrant staff in times of emergency and what measures currently exist or could be put in place as part of a wider preparedness and prevention plan. It would also be useful to know what risks factory workers and casino workers face, and what preparedness measures should focus on.

16. Conduct further research into the attitudes and behaviours of host communities in Vietnam and Cambodia towards migrants so this information can be used in developing pandemic preparedness measures and interventions that specifically address the needs of migrant groups. Ensure that all future strategies and activities assess the potential for creating stigma and discrimination against migrant workers. Where needed, incorporate mitigation strategies, especially when implementing activities that may single out migrants, such as health assessments.

## I. Introduction

### A. Background and justification<sup>2</sup>

Many countries have responded to the threat of avian influenza at both national and community levels, although to varying degrees. Some countries have adhered to World Health Organization (WHO) pandemic preparedness guidelines, as well as to those of the International Health Regulations<sup>3</sup> and the Asia Pacific Strategy for Emerging Diseases<sup>4</sup>. Some countries have addressed the maintenance of essential services, the prevention and rapid containment of avian influenza and the mitigation of the socio-economic consequences of a pandemic. However, cross border areas and the people who live, work and move through them have not been sufficiently addressed in pandemic preparedness strategies worldwide. Although some national strategies have identified cross border areas as an issue of importance in avian influenza transmission, the specific needs of migrants and cross border communities, as well as the pandemic preparedness capacity of border control and public health officers, warrant further attention.

While the movement of goods, livestock and people across borders is essential to international trade and cooperation between countries, ill-prepared or unprepared border zones may be considered as potential channels for the spread of avian and human influenza in both pre-pandemic and pandemic scenarios. Some regions are more advanced than others in addressing the issue of border control measures as part of pandemic preparedness. The emergence of the H5N1 avian influenza virus in the Asian region called for tighter control of

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<sup>2</sup>This section has been slightly modified from the Asia Component (Cambodia-Vietnam and Bangkok) of the Pandemic Preparedness for Migrants and Host Communities Project, Summary Project Document, IOM, 2008.

<sup>3</sup> WHO, *International Health Regulations*, Geneva, 2005. See Application of the International Health Regulations, Fifty-Ninth World Health Assembly (WHA 59.2), 26 May 2006 (available at [www.who.int/gb/ebwha/pdf\\_files/WHA59/WHA59\\_2-en.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA59/WHA59_2-en.pdf)).

<sup>4</sup> WHO, *Asia Pacific Strategy for Emerging Diseases*, Geneva, 2005 (available at [www.wpro.who.int/NR/rdonlyres/FCEEBB9D-21BB-4A16-8530-756F99EFDB67/0/asia\\_pacific.pdf](http://www.wpro.who.int/NR/rdonlyres/FCEEBB9D-21BB-4A16-8530-756F99EFDB67/0/asia_pacific.pdf)).

the cross border movement of livestock and poultry. Some countries have taken measures to increase surveillance at border crossings and prohibit the importation of poultry. Many countries have not included the needs of migrants in their humanitarian and pandemic preparedness planning interventions.

As part of the IOM Pandemic Preparedness for Migrants and Host Communities Project, a situational analysis was conducted in Svay Rieng, Cambodia, on knowledge, attitude, practice and behaviour (KAPB) regarding preparedness for pandemics and responses to emergencies. This included a series of focus group discussions (FGDs) with key migrant groups and community health workers in selected areas along the border of Svay Rieng.<sup>5</sup> The FGDs were designed to ascertain the level of pandemic preparedness and knowledge of selected migrant and host communities, civil society, public health authorities and border control personnel. Building on the results of several KAPB surveys conducted in both the Cambodia and Vietnam sites,<sup>6</sup> this report presents findings from the Cambodian side only.

The data obtained from the FGDs was analysed and will be used to design further interventions for the Project in order to strengthen the capacity of migrants and receiving communities, and district and provincial health and non-health sectors to cope with pandemics or other crises<sup>7</sup>. The results of the situational analysis will then be translated into Vietnamese and Khmer languages and shared among government and United Nations (UN) partners and key stakeholders.<sup>8</sup>

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<sup>5</sup> Focus Group Discussions Report, IOM, November 2008. A summary report on the process of the FGDs is attached as annex 3.

<sup>6</sup> Refer to footnote 1.

<sup>7</sup> Refer to footnote 4.

<sup>8</sup> Refer to footnote 1.

## **B. Project Summary<sup>9</sup>**

IOM is contributing to global efforts in preparedness planning for avian and human influenza and other pandemic threats through its participation in the Avian and Human Influenza Consolidated Action Plan for Contributions of the UN System and Partners. With anticipated funding from the United States Agency for Development through the UN Central Fund for Influenza Action for 2008-2009, IOM will implement the pilot phase of the Pandemic Preparedness for Migrants and Host Communities Project through its missions in Cambodia and Vietnam. This implementation will be done in collaboration with UN agencies, government partners and other stakeholders as part of the UN Consolidated Action Plan's objective 6, which aims to raise awareness and strengthen pandemic preparedness in cross border migrant communities with pilot activities in the border provinces of Svay Rieng (Cambodia) and Tay Ninh (Vietnam).

IOM's pilot programmes on pandemic preparedness in Cambodia and Vietnam will have three primary activities:<sup>10</sup>

- a) conducting KAPB surveys and FGDs for relevant stakeholders in Svay Rieng and Tay Ninh
- b) using the outcomes of the KAPB surveys and FGDs to design and conduct pandemic preparedness training workshops in Svay Rieng and Tay Ninh
- c) conducting tabletop exercises among relevant stakeholders in Cambodia and Vietnam.

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<sup>9</sup> The first four paragraphs are sourced directly from the Asia Component (Cambodia-Vietnam and Bangkok) of the Pandemic Preparedness for Migrants and Host Communities Project, Summary Project Document, IOM, 2008.

<sup>10</sup> Internal IOM strategic framework for the Cambodia component of the Pandemic Preparedness for Migrants and Host Communities Project, IOM, 2008.

These activities are designed for two primary purposes:<sup>11</sup>

- a) to identify the extent to which current and/or proposed pandemic preparedness strategies in each country are conducive to addressing the specific needs and vulnerabilities of their respective migrant and host communities
- b) to help service providers, particularly government and civil society actors, to incorporate the specific concerns of mobile populations and host communities into pandemic preparedness strategies.

IOM's guidelines (strategic priorities), which are based on field visits and discussions with UN and government counterparts are as follows:<sup>12</sup>

*Focus on pandemic preparedness/disaster management:* Discussions with government and UN partners have revealed a general consensus that the concerns about avian and human influenza that led to the development of this project are better addressed through activities that focus on broader pandemic preparedness issues rather than on specific diseases and disease responses.

*Support Cambodia's decentralized/multi-sectoral approach to pandemic preparedness/disaster management:* Pandemic preparedness and response in Cambodia is, and will continue to be, primarily the responsibility of provincial governments. With significant technical support from WHO, the government is undertaking an intensive provincial planning process designed to build provincial-level capacity for pandemic preparedness/response. The goal of IOM is to ensure that, through advocacy and/or specific programmatic interventions, migrants and mobile populations are taken into consideration in this strategy.

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<sup>11</sup> Refer to footnote 8.

<sup>12</sup> Refer to footnote 9.

*Provide information/tools that directly address province-specific concerns:* One of the primary tasks of IOM is to identify specific barriers (social, economic, institutional, geographic, etc.) that may prevent migrants and mobile populations from actively participating in pandemic preparedness/response strategies and/or may prevent service providers from addressing the specific vulnerabilities of migrant and mobile populations in pandemic outbreaks. While some issues will be common to all migrants and mobile populations, such as access to correct information and health care, there will be many province-specific concerns that will need to be addressed through tailored responses.

### **C. Purpose/objectives**

As outlined in the Asia Component (Cambodia-Vietnam and Bangkok) of the Pandemic Preparedness for Migrants and Host Communities Project Summary Document, the overall goal, the objectives and the expected outcomes of IOM's planned work are as follows:

#### *Goal*

The goal of the Project is to contribute towards national, regional and global efforts in avian influenza response and pandemic preparedness by contributing to the Avian and Human Influenza Consolidated Action Plan for Contributions of the UN System and Partners, objectives 6 and 7 (revised September 2007).

The main aim is to ensure the continuity of essential social, economic and governance services and the effective implementation of humanitarian relief under pandemic conditions for migrant populations.

### *Specific objectives*

The specific objectives of the Project are:

- a) to increase capacity in community-based surveillance, prevention, home-based management of communicable diseases (including influenza-like illnesses) and social well-being of migrant communities in the event of a pandemic or other crisis
- b) to conduct pandemic preparedness information and social mobilization activities for migrant communities, civil society and border control agencies
- c) to strengthen national and particularly district and community capacities to include the needs of migrants in disaster preparedness and pandemic contingency plans.

### *Expected outcomes<sup>13</sup>*

- a) *Objective 3.3.4 (Human Health):* Access to health needs and services for migrant populations at risk of avian influenza or any potential future pandemic
- b) *Objective 5.2.5 (Public Information and Communication to Support Behaviour Change):* Government behaviour change strategies for migrants
- c) *Objective 6.1.10 (Continuity under Pandemic Conditions):* Operations in place to respond to the needs of migrants and mobile populations.

Programme partners include ministries of health and their provincial health authorities in both Cambodia and Vietnam, the UN System Influenza Coordinator, WHO, the United Nations Children's Fund, the Food and Agriculture Organization of the United Nations, and

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<sup>13</sup> These objectives fall within the objectives outlined in the Avian and Human Influenza Consolidated Action Plan for Contributions of the UN System and Partners (revised September 2007).

international and national non-governmental organizations (NGOs) working on avian influenza and pandemic preparedness.

The target groups are migrants and host communities living in cross border districts in Svay Rieng, Cambodia, and Tay Ninh, Vietnam; civil society, district border control, public health and other government agencies (public health officers, police, customs officers, border control officers), NGOs and community-based organizations.

## **II. Methodology**

### **A. Development of FGD guidelines**

An international consultant completed the first draft of the guidelines for the FGDs, which were pre-tested in Svay Rieng. These were then shared with the Deputy Governor, and WHO and IOM national government counterparts, and then finalized.<sup>14</sup> Please see annexes 1 and 2 for the FGD guidelines.

### **B. Location**

The research was carried out in Svay Rieng. The decision to select the border province of Svay Rieng was based on several reasons. In the Greater Mekong Subregion, there are existing joint-action border health programmes between Thailand and Cambodia, between Cambodia and Lao PDR, between Thailand and Lao PDR, and between Thailand and Myanmar and Cambodia-Vietnam. These programmes focus on communicable disease control along the borders in order for governments to adhere to the guidelines of the International Health Regulations and the Asia Pacific Strategy for Emerging Diseases. However, the Cambodia and Vietnam cross border health programme is not as well funded as

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<sup>14</sup> Refer to footnote 9.

the other cross border programmes. During the severe acute respiratory syndrome (SARS) crisis, IOM worked with Cambodia's national border control agencies in monitoring the disease among mobile populations. In September 2007, IOM supported the third cross border health meeting between the ministries of health of Cambodia and Vietnam at their request.

Additionally, IOM maintains a sub-office in Svay Rieng that implements a project on the counter-trafficking of human beings. Through this project, IOM identified that there were a number of active cross border migrant communities in Svay Rieng and Tay Ninh. In the past, IOM also implemented activities in the area, such as providing health screening for Cambodian returnees in partnership with the DSVY.<sup>15</sup>

### **C. Sample groups**

The following groups were the participants in the FGDs:

*Cambodian returnees:* The participating Cambodian returnees had either been assisted in returning from Vietnam to Cambodia as irregular migrants or were the parents of returning victims of human trafficking.

*Garment factory workers and casino workers:* Garment factory workers and casino workers were a concern because factory and casino owners tend to keep their workers and activities relatively isolated from the community. This led IOM to develop a close relationship with the DoLVT in Svay Rieng, so as to facilitate contact with these particular migrant groups.<sup>16</sup>

*Vietnamese migrants:* These Vietnamese migrants have been living in Svay Rieng for a few years and are engaged in trading goods there, but they do not appear to have integrated into the local communities, and have very limited knowledge of the Khmer language. This raises

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<sup>15</sup> Refer to footnote 9.

<sup>16</sup> Refer to footnote 1.

concerns about their access to culturally appropriate and language appropriate information and health-care services, particularly in the event of a pandemic.

*Village health support groups (VHSGs):* VHSG members and village chiefs (often members of VHSGs) were asked to participate as they are the front-line response for health needs in villages and communities.

#### **D. Research team/recruitment**

Any pandemic preparedness approach should include health and non-health sectors. Multi-sectoral capacity building at the community level for pandemic preparedness is highly encouraged and considered crucial in line with objective 6 of the Avian and Human Influenza Consolidated Action Plan for Contributions of the UN System and Partners.

The IOM office in Svay Rieng has existing partnerships with the provincial authorities. In an effort to actively engage non-health sector counterparts from other ministries, 13 male FGD facilitators were identified and trained. Of the 13, 9 were from DSVY, 2 from the DOH, and 2 from DoLVT. While efforts were made from the beginning of the Project to encourage female DSVY staff to be part of the FGD, they expressed no interest in work that involved travelling to the community.

The nine DSVY staff members work as counterparts of the IOM counter-trafficking project in Svay Rieng, where they provide direct return and reintegration assistance to returning trafficking victims and other vulnerable irregular migrant returnees from Vietnam. They are also familiar with the Vietnamese migrant communities in the areas along the border.

The two DoLVT administrative office staff are directly involved in the liaison, coordination and collaboration with all garment factories and casinos in Svay Rieng.

The two DOH staff are members of the DOH Rapid Response Team, who are “primary responders” to any health-related emergencies. They collect health-related information and other evidence and forward this to the national level for other technical advice, support and follow-up. They are also involved in providing community health workers with training.

The staff from these departments were selected because they are able to facilitate access to migrant groups. It is also envisaged that future pandemic preparedness capacity building activities will include the continued engagements of these provincial authorities in Svay Rieng and these migrant communities.

## **E. Implementation of FGDs<sup>17</sup>**

*1. Initial steps:* Once a letter had been obtained from the Svay Rieng Provincial Governor’s Office to facilitate the implementation of IOM’s activities with district and provincial authorities, an IOM project assistant was installed in Svay Rieng. The project assistant worked with the relevant provincial departments, including DOH, DSVY and DoLVT, to identify the migrant group participants for the programme activities.<sup>18</sup>

*2. Training of trainers:* A half-day FGD training of trainers for three IOM staff (two project assistants and one national project officer) was conducted in Svay Rieng by an IOM international consultant. The training focused on:

- terminology, including “emergencies” and “pandemics”

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<sup>17</sup> For parts 1, 3 and 4, refer to footnote 4.

<sup>18</sup> Refer to footnote 4.

- why FGDs are used
- how to select participants and where to conduct an FGD
- skills required for an FGD moderator
- what an FGD moderator should and should not do
- how to take notes and how to write a report on an FGD
- how to use the guideline questions.

3. *Moderator training:* The three IOM FGD trainers developed a curriculum and then, on 17 September 2008, conducted a one-day FGD training at the IOM/DSVY Project Office for the 13 nominated moderators. The training was designed not only to provide skills for conducting FGDs and taking notes, but also to familiarize participants with the guideline questions for migrants (annex 1) and the guideline questions for VHSGs (annex 2). The training focused on the skills and characteristics of a moderator and a note taker, followed by a review of the guideline questions, and finished with a role play to practice the skills learned.

4. *Mobilizing FGD participants:*

- **Cambodian returnees:** The Cambodian returnees were selected by DSVY caseworkers for an FGD on 12 September 2008. The participants included both men and women. One FGD was held in the village of Teng Mao in Chantrea District and the other in the village of Kandal in Kompong Ro District.
- **VHSGs:** VHSG members and village chiefs who participated in previous IOM-sponsored information, education and communication trainings were invited by DOH to participate in the FGD. Two different FGDs were held in Mesor Tngork in Chantrea District by staff from DOH and DSVY. One FGD was conducted on 17 September and the other on 20 September.

- Garment factory workers: FGDs with the garment factory workers were arranged by DoLVT and held on 23 September 2008 at the Cambodian Garment Factory, situated along the national road 10 km from the Bavet border. It was conducted jointly by IOM, DSVY and DoLVT. The morning session was held with female workers and the afternoon with male workers.
- Vietnamese migrants: Interviews with Vietnamese migrants were conducted by DSVY caseworkers on 24 September 2008. Two sessions were held, consisting of both male and female participants. The first FGD was held in the village of Ta Beb in Bavet Commune, while the second took place in the village of Po in Mesor Tngork Commune, Chantrea District.
- Casino workers: Casino workers from the Las Vegas Sun Casino participated in FGDs near the Bavet international border crossing on 25 September 2008. The casino workers were identified by DoLVT, with one FGD consisting of male casino workers and the other of female casino workers. They were conducted jointly by staff from DoLVT and DSVY.

5. *Audio recording:* FGDs were facilitated with the use of the guidelines (see annexes 1 and 2) and were recorded on audio tape.

6. *Moderator reflection session:* Upon completion of the FGDs, IOM held a reflection session on 17 October 2008 with all the FGD moderators and note takers from DSVY, DoLVT, and DOH. The report reflecting the outcome of this meeting is attached in annex 3. The purpose of the meeting was for the moderators and note takers to reflect on their experiences, impressions and observations of the respondents' participation in the FGDs. It was agreed that the FGDs were conducted in an entirely voluntary and participatory manner.

Moderators and note takers gave feedback after each session so they could assess what they felt they had done well, and what they were not confident about and why, and develop helpful strategies and solutions. As a result, in addition to attaining increased knowledge about the migrant communities, the moderators and note takers became more confident and enthusiastic in their work with their communities and migrant groups.

*7. Transcription and translation:* The recorded FGDs were transcribed and translated by a professional translation company, facilitated by IOM's procurement department.

*8. Write-up:* An international consultant was hired by IOM to review the transcriptions and write the present report.

## **F. Limitations**

### **1. Qualitative analysis**

There are limitations in the use of qualitative and FGD research methodologies. This is described succinctly in the following quote from the Academy for Educational Development, which explains the value of this type of research: "It should be noted that this research is qualitative in nature. Its purpose is not to find out how many people engage in a certain behavior or hold certain positions, but to identify the kinds of behavior and opinions that do exist, and the possible reasons for this behavior."<sup>19</sup> IOM also conducted a quantitative survey on the same range of issues, which will be analysed in conjunction with the FGD results.

### **2. Translation of transcripts**

With the exception of the two VHSG transcripts, which were transcribed and translated in

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<sup>19</sup> Academy for Educational Development, "Handbook for excellence in focus group research".

full, all the translated transcripts were summarized in points and were not verbatim in the English translation. Some were more abbreviated than others; for example, the transcripts of the casino workers were more greatly summarized than those of the Cambodian returnees. The questions asked by the interviewers were also summarized in the translated transcripts. While it is noted that, in order to save time, the translators summarized the notes from the FGDs rather than from the actual audiotapes, the lack of full transcripts makes it difficult to comment on the development of the capacity of the moderators, who were all newly trained. This also makes it difficult to check (a) word usage, (b) whether the full meaning of what a participant had said was accurately captured and translated, and (c) whether any confusion on the part of the participants was possibly due to the facilitators not asking questions correctly or not effectively prompting responses. These are all important pieces in evaluating the success of the methodology, including the training of facilitators and their learning experience over the course of this activity.

Because the FGD facilitators were inexperienced, there are some sections in which only one or two respondents in a group answered the question, or occasions when questions were not asked of a migrant group. Although the lack of responses makes it difficult to draw conclusions, the responses that were given were used as data and give a picture of the issues. This also indicates that future training with these moderators may include further work on how to draw more detailed answers from migrants who, for a range of reasons, may be reluctant to answer some questions, may not be used to being asked for their opinions, or are new to participating in an FGD.

### 3. Gender and ageing<sup>20</sup>

Some of the FGDs consisted of both men and women, while others were separated by gender. IOM staff noted that the moderators did not feel that the migrant groups needed to be segregated and tried to have equal numbers of men and women migrants in each group, depending on the availability and willingness of the participants. The factory and casino managers requested that their staff participate in mixed groups as this fit better with the availability of the workers.

If there had been separate male and female FGDs for each population group, a gender analysis of the information collected could have been possible. If differences were identified, future activities that better target the specific needs, concerns and roles of men and women could be developed. With a mixed sample, however, this is not possible. It is important to discover why some people or groups were not available to participate as this may also impact on intervention decisions. Similarly, the female workers' unwillingness to participate as moderators in the communities is important to note as this could have an impact on their ability to conduct and respond to actions in a pandemic. The mixed groups did, however, have an equal representation of men and women. It is also possible though that, for cultural reasons, women will participate less or be reluctant to share their ideas or experiences if they are in a mixed group, depending on the skills of the moderator.<sup>21</sup>

The selection of the FGD participants could have also provided an opportunity to learn how different age groups are impacted by, and prepare for, pandemic and non-pandemic emergencies, as well as to gauge their vulnerabilities, needs and understandings with regard

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<sup>20</sup> "Ageing" takes into account the diversity of the needs and capacities of people as they grow older, from *Active Ageing: A Policy Framework*, WHO, April 2002.

<sup>21</sup> IOM project staff indicated that the moderators were skilled at encouraging all respondents to participate in the discussions. As noted in the limitations section above, for the purposes of this report this was difficult to assess due to the summarized translation of transcripts. For further analysis of the participation of women in FGDs and the skills of moderators in encouraging participation, a review of audio transcripts would be needed.

to illness, accessing health-care services and health education, and so forth. The separation of migrant groups into men, women, youths, and men and women over 50 years of age, for example, may have produced more detailed information to create better strategies and actions. IOM staff noted that the moderators felt it was important to separate children from adults when conducting an FGD.

### **III. Detailed Findings**

#### **A. FGDs with several key migrant groups: factory workers, casino workers,**

##### **Vietnamese migrants and Cambodian returnees**

The majority of factory worker, casino worker and Vietnamese migrant respondents had been in Cambodia as migrant workers for an average of one to four years. The Cambodian returnees worked as migrants in a seasonal capacity, going to Vietnam for short periods of time (two weeks to two months). One Vietnamese respondent, a farmer, also stated that they supplemented farming with seasonal work in construction. When asked about whether they liked the work they did, responses from the Cambodian returnees included the following quote: “Yes, we do because we have no capital to do business, have no land to farm. Working for others is the solution. We also sell vegetables, produce mats, handicraft work...and grow vegetables for others.” The garment factory workers said that they liked that they were able to learn a wide variety of skills and receive training.

The migrants, with the exception of the Cambodian returnees, were not strongly dissatisfied with the work they were doing, but there was recognition that, in order to earn money, they were sometimes at risk of exploitation. Casino workers were unanimously satisfied with their working conditions, but some factory workers said they were concerned about the possibility of not having work. They did not report that there was a lack of clarity in their work, however. Cambodian returnees listed a range of issues that caused them to dislike their work

situation, and their statements included the following: “To work as an employed labourer is not easy...we cannot avoid being exploited or cursed”; “Whether or not I like the job, I still have to work for the money” and “I have been cheated very often”.

**Table 1. How earnings are spent**

<b>How earnings are spent</b>	<b>Casino workers</b>	<b>Factory workers</b>	<b>Vietnamese migrants</b>	<b>Cambodian returnees</b>
Daily expenses for self/family (gasoline, clothes, food/rice, electricity, water)	XXX	XXX	XXX	XXX
Money sent home/family support	XX	X		
Buy clothes to send home	XX			
Health care/medical expenses			XXX	XXX
Children’s schooling (clothes, fees, books, pens)		XX	XX	XX
Buy fertilizer/poultry			X	X
Buy gems		X		

*Note:* XXX (most respondents), XX some respondents, X single respondent

**Table 2. Reasons for working as a migrant in Svay Rieng/Vietnam**

<b>Reason</b>	<b>Casino workers</b>	<b>Factory workers</b>	<b>Vietnamese migrants</b>	<b>Cambodian returnees</b>
Salary/earn money (to support family)	XXX	XXX		XXX
Look for better job opportunities	X			
Gain experience	XXX			
Appropriate accommodation/good environment	X	XX		
Further education				
Close to home		X	X	
Easy to trade			XXX	
Seasonal work possible (collecting crops, construction work, cooking, making handicrafts, planting watermelon)				XXX
Pay for medical expenses				XXX

*Note:* XXX (most respondents), XX some respondents, X single respondent

After reviewing the two tables above, it appears that Cambodian returnees and, to a lesser extent, Vietnamese migrants migrate for work in order to meet urgent and essential needs. While the factory workers and casino workers may also be meeting urgent and essential needs through sending their earnings home to support their families, their immediate situation is more stable.

## 1. Help-seeking behaviour

There are striking differences among the migrant groups regarding the impact of illness. For the Vietnamese migrants and Cambodian returnees, illness often leads to difficult circumstances and greater vulnerability, and they have a greater vulnerability to the impact of natural disasters due to the nature of their work. The factory workers and casino workers identified their main problems and concerns to be unemployment, family conditions and a lack of money for education.

**Table 3. Problems/concerns over previous year**

<b>Problems /concerns over previous year</b>	<b>Casino workers</b>	<b>Factory workers</b>	<b>Vietnamese migrants</b>	<b>Cambodian returnees</b>
Lack of money to study/for education	XX	X		
Family conditions (no parents, too many siblings)	XXX	X		
Unemployment/underemployment	XX	XXX		
Poor standard of living	X			
Poor quality of food/drinking water	X		X	XX
Illness/poor health leading to financial problems			XXX	XXX
Trade only in vegetables, nothing larger			X	
Poor harvest			X	XX
Drought – impact on ability to work				XX
Flood – impact on ability to work				XX

*Note:* XXX (most respondents), XX some respondents, X single respondent

There were great differences among the various migrant groups regarding whom they talked to about their problems and whom they turned to for help. However, problems were primarily discussed by all groups with family members, relatives, village health staff and neighbours. At times, problems were also discussed with the local authority and NGOs.

Unlike the other groups, the casino workers did not mention the local authority or external organizations as places where they would go to discuss problems, with the exception of a

doctor (however, no detailed information was available about where a doctor could be accessed). This suggests that they are more removed from local authority and services structures. The casino workers did, however, mention seeking help for a problem from the local authority; however, co-workers, friends, supervisors and neighbours were the other sources of assistance. The factory workers also emphasized that their family was their primary source of support when talking about problems. They also mentioned a range of local authority figures and service providers; however, they only sought assistance for problems with family and friends/co-workers (only one group was asked this question). The Vietnamese migrants emphasized that they sought help from a Vietnamese hospital if they had health problems, while the Cambodian returnees uniformly identified the village or commune authority as where they would turn to when they needed assistance, in contrast to a wide range of people with whom they would discuss a problem.

Regarding their concerns, all the migrants said that poor health and illness were a potential problem as they felt they would not be able to afford treatment, followed by losing their job or being unable to find work and not having enough money. The Cambodian returnees also identified drought, flood, avian influenza, lightning, war, starvation, and not being able to buy materials for their children to study as things to be feared.

**Table 4. Whom the migrants talk to about problems and whom they get help from**

Whom the migrants talk to about problems	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees	Whom the migrants get help from	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Family members (husband, parents, siblings)	XXX	XXX	X	XX	Family members (husband, parents, siblings)		XX	X	
Relatives	XX	XX			Relatives				
Friends		X			Friends/co-workers	X	XX		
Head of village/commune			XXX		Head of village/commune			X	XXX
Self				X	Self			X	
Village health staff/doctor	XX			X	Village health staff/doctor				
Neighbour	XX		XX		Neighbour	X		X	
NGOs		XX		X	NGOs				
Labour department		XX			Labour department				
Lending programmes				X	Lending programmes				
Social affairs/police/authority			XX	X	Social affairs/police/authority	X			
Company/supervisor		XX			Company/supervisor	X			
					Vietnamese hospital			X	

*Note:* XXX (most respondents), XX some respondents, X single respondent

The majority of migrant groups received new information from television, radio, friends, and the village and commune chief. Health education was identified as coming from organizations such as the Reproductive Health Association of Cambodia (RHAC) and IOM, radio, magazines, posters, leaflets, television, company leaders, family, and health staff and doctors. The Vietnamese migrants focused on television and radio as their primary sources of information, while the Cambodian returnees accessed information from a wide range of sources.

The casino workers identified social diseases, drug abuse, how to protect oneself from diseases, HIV testing and HIV prevention, birth spacing, and reproductive health as health education topics that they had learned about. Most casino workers felt that this information was useful as it gave them knowledge to protect themselves and to prevent diseases. The female casino workers further mentioned learning how to prevent themselves from being cheated, as well as being able to then disseminate this knowledge to others. The factory workers said they had learned about hygiene, health care, the importance of cleaning equipment and eating hygienic food. The Vietnamese migrants said they received information on the need for exercise, and stopping smoking and drinking, and felt this was useful because “it strengthens our health” and “because we and our families can prevent [illness]”. The Cambodian returnees provided the most extensive list of health topics that they had learned about, including vaccination, breast feeding, supplementary feeding of infants and children, dengue fever prevention, diphtheria, tuberculosis, goiter, respiratory problems, and avian influenza. They felt the health education was useful. One respondent said: “We are much aware of the importance of using condoms, birth spacing programmes, maternity care, dengue fever prevention methods such as sleeping inside a mosquito

net, eating nutritious and healthy food, avian influenza prevention such as not eating diseased poultry, instructing children to drink clean water, and washing your hands before you eat.”

The groups were asked what they thought was the best way to provide health education to migrant workers. They all understood this question to be asking what information they felt migrants should have. The key messages they identified were exercise, food sanitation, eating regularly, not drinking alcohol, wearing a helmet and mask (factory workers), drinking clean water, sleeping inside a mosquito net, using soap, wearing clean clothes, and not having sex with someone other than one’s wife. The Cambodian returnees also mentioned the need to educate daughters about behaving well and eating healthy food. One Cambodian returnee suggested providing migrant workers with information by gathering villagers as a group and disseminating information through them.

## **2. Access to health care**

The casino workers, factory workers and Cambodian returnees go to health centres and buy medicine for self-treatment as an initial response to ill health. The results in table 5 suggest that most migrants will seek medical services only if they are seriously ill, and the Vietnamese migrants go to a Vietnamese hospital rather than access Cambodian services if they are seriously ill.

**Table 5. Access to health care: what migrant groups do**

<b>Question</b>	<b>Casino workers</b>	<b>Factory workers</b>	<b>Vietnamese migrants</b>	<b>Cambodian returnees</b>
What do you do when you feel sick?	Seek a cure at health centre; Buy medicine; Tell friends/parents.	See medical doctor at company Go to health centre; Go to private hospital; Self-treatment.	Go to Vietnamese hospital; Coining; Buy medicine; See doctor; “Not go to Khmer health centre”.	Buy medicine; See medical assistant for treatment; Go to health centre; Go to private clinic/hospital.
When do you decide to seek help?	Seriously ill (can’t stand up, high temperature, dizzy)	Seriously ill	Seriously ill	For a cold/fever buy medicine, coining or traditional massage, ask for help from relatives or neighbours; For a serious condition, go to medical clinic.
Where do you go to get help?	Go to health centre; Go to hospital.	Self-treatment; Company hospital; Private hospital; Health centre	If serious, to Vietnamese hospital; If not serious, other doctor; Help from village or commune leader.	Health centre; Referral hospital; Private clinic; Village physician; District office or provincial social welfare department.
Whom do you see?	Doctor	Doctor	Doctor in Cambodia for minor health problems and doctor in Vietnam for more complicated/serious problems	Physician; Family member; Traditional healer; Health centre staff (Note: hospital closure on Saturdays and Sundays identified as a barrier).

When asked about the previous time they went to see a doctor and how useful they found the care, most respondents said they felt it had been a useful experience because they had been provided with medical care and information, and been cured. The casino workers identified the following problems with the treatment: difficult to take a “waiting number”; hospital not very hygienic; health staff offensive and doctors treating only those who had money to pay for it. The factory workers said that they could spend a lot of time waiting to receive services, there were a lot of people

waiting for treatment, it was hard to take the medicines<sup>22</sup> and they were afraid of the diagnosis or of being ill. The Vietnamese migrants and the Cambodian returnees said problems included fees for the services, and that it was difficult to access the health-care services due to the poor condition of the roads and the lack of transport.

Migrant groups identified the following difficulties in accessing health-care services: the need to travel long distances; doctors ignoring patients; having no money to pay for services; no medicines at the health centres and no health centre in the village. In contrast, the Cambodian returnees from Kampong Ro District seemed very happy with the medical care they received, saying that there were always medical staff standing by and all of the Cambodian returnee respondents could get medicine immediately once they arrived at the hospital.

The respondents proposed the following ideas on how health care could be made easier for them: “home visits by a doctor” (suggested by a female factory worker); “have a doctor available in the village”; “the doctor should be more attentive and polite”; “repair roads so it is easier to travel”; “have good quality medicine” and “have medical staff available at the health centre at all times”.

When the respondents were asked what they did to stay healthy, they answered the following (in the order of number of times mentioned): get enough sleep; eat good, sanitary food; wash oneself; exercise; have a clean house; entertain/relax; wear masks while working (factory worker); drink boiled water; do not drink alcohol; sanitation, including a container to store rubbish; have medical check-ups and destroy mosquito breeding sites.

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<sup>22</sup> This comment is a direct quote from summarized transcripts (please refer back to the limitations section) and it can be assumed that this means “difficulty with taking medication”.

When reviewing table 6 below, it is striking that the casino workers seem to get most of their information from sources they would access at their place of work. Both casino workers and Vietnamese migrants do not identify family or friends as sources of information. Both the Vietnamese migrants and the Cambodian returnees received information from the health centre and village health staff. However, neither the casino workers nor the factory workers mentioned them as a source of information, which suggests that they are isolated from the DOH system.

**Table 6. Sources of information on health**

Source	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Doctor	X	X	X	X
Magazines	X			
Television	X	X		
RHAC/NGOs	X			X
Community fund	X			
Company director		X		
Radio		X	X	X
Friends		X		
Family		X		X
Pictures (posters)		X		
Health centre/village medical staff			X	X
Study			X	

### 3. Pandemic preparedness

Common illnesses mentioned by at least two migrant groups were colds, cholera, hepatitis, high blood pressure, hemorrhagic fever and tuberculosis.

**Table 7. Common illnesses (illnesses perceived by migrants as most serious are in yellow)**

Common illnesses	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Diarrhea	X			X
Flu/cold	X	X		
“Internal pain”	X			
Cholera	X	X		
Dengue fever	X			X
Syphilis	X			
Hepatitis	X		X	
High blood pressure	X		X	
Chickenpox		X		
Itchy skin		X		
Red-eye disease		X		
Flu		X	X	
Hemorrhagic fever		X		
AIDS			X	
Avian influenza			X	
Nausea			X	
Dizziness			X	
Diabetes				X
Fever		X		X
Measles			X	
Tuberculosis			X	X
Malaria				
Vomiting				

Only one Vietnamese migrant group responded why they felt these diseases were serious. They responded with a specific reference to avian influenza: “Because it can cause death immediately.”

**Table 8. Illnesses that caused many people in one community to become sick**

Illness	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Traffic accident	X			
Hepatitis	XX		X	
Tuberculosis	X		X	
Avian influenza	XX			X
Dengue fever	XX			X
High blood pressure	XX		XX	
Hemorrhagic fever		X		
Flu/cold		X		X
Cancer			X	
Diabetes			X	X
Typhoid				X
Diarrhea				X
Red-eye disease		X		
Cholera				X
Measles				X

Note: XXX (most respondents), XX some respondents, X single respondent

All migrant groups believed that, from their experiences, ill people got better. Treatment was managed by doctors and with medicines. The factory workers made the point that the factory bought the medicines for them and would take them to the hospital. One Cambodian returnee said the following: “Now they have recovered. We received help from NGOs, physicians at health centres, private clinics, some state hospitals (which provide treatment free of charge)...We received some support from IOM and social welfare, who take us to receive health services free of charge.”

Both avian influenza and HIV/AIDS were identified by all migrant groups as illnesses that could spread between communities.

**Table 9. Illnesses identified by respondents that could spread between communities or globally (diseases they worry about are highlighted in blue)**

Illness	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Avian influenza	X	XX	X	XX
Social diseases (presumably STIs)	X			
Dengue fever	X	X		XX
HIV/AIDS	X	XX	X	XX
Malaria		X		
SARS		X		
Hemorrhagic fever		X		
Red-eye disease		X		
Cough				
Tuberculosis			X	
Cholera				X
Measles				X
Vomiting				X
Stomach ache			X	
Diarrhea			X	
Nausea			X	
Cancer			X	
Hepatitis			X	
Disease that kills pigs, chickens and ducks				X
Diphtheria				

Note: XXX (most respondents), XX some respondents, X single respondent

The Vietnamese migrants stated they were worried about tuberculosis and cancer because they could not be cured. When asked directly about SARS, HIV, avian influenza, malaria and dengue fever, the Vietnamese migrants stated that they had heard about these diseases, that they did worry about getting one of these diseases and if they did, they would go to Vietnam for medical care. The Cambodian returnees were concerned about these diseases as they “cannot be predicted and could happen to us at any time”. Other statements regarding concerns included the following: “If it happens, it will be hard as we are so poor” and “I worry that my husband may bring AIDS home as he works so far away from home”.

When asked about avian influenza and how to prevent it, all the migrant groups were able to respond with the following preventative measures: “not eating sick birds”; “reporting incidents to a capable person”; “having clean bodies”; “keeping poultry cages clean”; “washing hands with soap after touching poultry” and “cooking poultry well”. The factory workers added the following measures: “wearing a mask when slaughtering animals”; “burying or burning dead birds” and “preventing children from touching poultry”. The Vietnamese migrants further stated that “building the poultry cage away from the home” would be a step in prevention. All respondents cited television as a key source of information. Radio, advertisements from organizations, leaflets, pictures, and the dissemination of information by village and commune staff were also listed.

The following personal protection measures were listed by the casino workers in the case of an outbreak of avian influenza: “wear masks and gloves”; “keep new chickens separate from other livestock for 14 days”; “cook poultry well” and “clean the water

tank and pot often”. All migrant groups stated they would inform the local authority (village and commune) and health staff if an outbreak occurred. Other key people the Cambodian returnees would wish to inform include the following: “NGOs”; “animal health workers”;<sup>23</sup> “neighbours”; “commune’s department of agriculture” and “the community network” (to help with the response).

#### 4. Non-pandemic emergency preparedness

When asked to think about emergency situations, the migrant groups listed floods, natural disasters, house fires, traffic accidents, storms, rain in the wrong season, lightning, no food, no electricity, drought, cholera, earthquakes, drowning, collapse of house, infectious diseases and seedlings destroyed by insects.

**Table 10. Emergencies migrants believe they are most likely to encounter**

Emergency	Casino workers	Factory workers	Vietnamese migrants	Cambodian returnees
Drought	X	XX	X	XX
Flood	X	XX	X	XX
House fire	XX			X
Storm	X		X	X
Traffic accident		X		
Fainting*		X		
Insects				X
Losing job	X			
Incurable disease	X			

*Note:* XXX (most respondents), XX some respondents, X single respondent

\* Fainting among factory workers is usually due to working long hours in order to receive a greater income and eating less.

Flood, drought and house fire were the emergencies migrant groups felt they were most likely to encounter. Some had also experienced these emergencies. The casino workers said the government of Cambodia and the Cambodian Red Cross would

<sup>23</sup> Animal health workers work in the community with animals that are reared for food, such as chickens, cattle and pigs.

respond to the emergencies. The Cambodian returnees further mentioned the World Food Programme, DSVY and Catholic Relief Services as those who assisted them. When asked about how they would prepare for such events, some of migrant groups' ideas included the following: "Plant more trees to avoid the drought, and not cut down trees" (casino workers); "Go to higher ground" (casino workers); "Be well prepared" (Vietnamese migrants); "We get ourselves ready with food supplies, medicines, some money, salt and salted fish, and rice, so that we can survive" (Cambodian returnees); and "We have made some plans, have fished to save up money to have a reserve in case problems happen" (Cambodian returnees).

Budgeting and putting money aside, storing food/rice and buying a supply of medicine were the three initial steps in preparing for emergencies listed by the casino workers, the factory workers and the Cambodian returnees.

**Table 11. Plans respondents made to prepare for an outbreak of disease or a natural disaster**

<b>Plans</b>	<b>Casino workers</b>	<b>Factory workers</b>	<b>Vietnamese migrants</b>	<b>Cambodian returnees</b>
Prepare budget/put money aside	X	X		X
Buy rice/food to store	X	X		X
Build tall houses/raise land	X		X	
Buy medicine	X	X		X
Keep housing compound clean		X		
Protect ourselves from mosquitoes		X		
Watch radio and television to monitor situation			X	
Build fence/doors to protect children from falling/being hit by traffic			X	
Have firewood reserves				X
Have axe, cleaver reserves				X

The only group who responded but did not have any plans was the male factory

workers, who said they did not plan as they did not know when bad weather would occur.

## **B. FGDs with village community health workers: VHSGs**

### **1. Self-perceived roles and responsibilities as community health workers**

The VHSG respondents consisted of village chiefs, traditional birth attendants and community health workers. One community health worker described their roles and responsibilities as follows: “I collect information on diseases in the village and advise people to go to the health centre for treatment...I receive information from the health centre to disseminate to people in the village.” They disseminated information on “telling pregnant women to give birth at the health centre”, “how to practice hygiene, drink clean water”, “advising that newborns receive immunizations to prevent seven childhood diseases” and “collaborating with other organizations in the development of the village”. Their other responsibilities included “taking sick people to the hospital”, “distributing larvicides (Abate) to put in water jars”, and “advising people to go to the health centre if they suspected they had tuberculosis”.

The VHSG respondents stated that they had received training twice a year from RHAC on tuberculosis and HIV/AIDS, and that they also received training from the provincial health department on issues such as avian influenza two to three times per year. Other training topics included breastfeeding, the importance of colostrums, child health, the consequences of pregnancy, and hygiene. One respondent went on to say: “NGOs and the government support the trainings. We have a duty to disseminate the information we have received training in to the people.” All the respondents felt that the trainings were important. One respondent said: “It allows us to help people when they have a problem.” They also said: “Training is very important to the VHSG

because it equips us with the knowledge to educate our people in our neighbourhood, particularly in the area of health.” Another respondent emphasized the need to talk about not only health but also the environment, and said: “If we want to protect ourselves from diseases such as malaria we have to keep our environment clean. Today there is no dumping ground for rubbish and there is no company responsible for collecting and disposing of waste, and this causes health problems.”

When asked if they had further training needs, the VHSG respondents identified training in the prevention of avian influenza and dengue fever, and health education. Many of the respondents felt that they had already received a lot of training and were very experienced, and there seemed to be some reluctance to answer the questions even after the facilitator asked them in a different way. Key difficulties that were discussed were how to get people in a village to come together to attend a health education session, followed by how to respond to the request villagers had for a snack if they came. Other challenges were water and waste management, and accessibility to the village, such as poor road quality.

The VHSG government contacts were identified as being the village chief, the commune leader and the district head (in hierarchical order). The VHSG respondents reported that they would speak with the commune leader, while the people of the village would talk to the village chief about their problems. A few respondents felt that they were not supported enough by the government structures in their work, and this was articulated as follows: “It is not as efficient as we wish. Whatever issues they can help resolve, they will resolve. What they cannot resolve, they send to a higher level.”

## **2. Help-giving behaviour**

The primary problems affecting people in the villages of the VHSGs were issues of health and the problems caused by flooded roads in the rainy season, which prevented people from accessing health workers. One respondent highlighted the impact of the poor standard of living in his community: “Our people have problems with their standard of living. They have problems with food shortages. They lack money. When people are poor they send their children to Vietnam begging for work from others.” The VHSG respondents felt they could assist the villagers with health issues such as fever, measles, diarrhea and high blood pressure, and could refer them to the health centre and hospital, but when they could not assist the villagers, they would sometimes become upset. One respondent also stated: “We can provide them with mental and physical support but not financial help. We can advise them where to go when they need help.”

When conducting health education, the respondents found flip charts, paper, posters, banners and pictures to be useful materials. One respondent emphasized the importance of pictures: “...for example, a cold – we need a poster to explain this disease. We cannot just explain this to them without showing them pictures as they would not be interested. Showing them pictures makes them understand it a lot better.”

When asked about migrants, one VHSG respondent defined a migrant as “a person who goes to work or do business in another area”. Some of the respondents said that they worked with migrants every day, while others met with them once a month or every other month, and reported conducting education with them. For example, a

VHSG respondent stated: “Well, we need to know their activities, when their holiday is. We want to see them, we need to know their typical schedule. We need to see them, which day we should go...we can meet them on these days. If not, we just send messages through their family members so that they help spread the information to their relatives who work in various factories.”<sup>24</sup>

When asked if they felt migrants might have special health problems, some participants responded by saying that they were in good health. Another respondent stated: “From what I have observed of the migrant population, they tend to have poor health as they go to another country to beg and have no land or home, so they have a lot of health problems. Because when they are in another country they stay under the awnings of other people’s houses and have poor hygiene, they have many health problems. In addition, they do not have access to education.” Another respondent said: “I see that the issue of health is a priority for them. In my area there are lots of factories and casinos, so it is very appealing for migrants. We are not sure if the migrant workers from different areas are healthy or have HIV/AIDS. It is just like a chicken, when we see it walking we do not know if it is sick or not. That’s why we need to help them as we do not want to see a situation where they bring diseases from their areas into ours and vice versa because migrants are mobile.... Our health workers also have difficulty managing this. In addition, there are many private practitioners who attract these people so our public health workers lose information on this.”

The respondents also felt that the migrants had access to help when they were sick as

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<sup>24</sup> Casino workers and Vietnamese migrants did not list family members as a source of their health education information.

they could go to Vietnam or receive services in Cambodia. They can access private doctors or health centres depending on their needs as well. Respondents stated that they felt that the migrant workers sometimes did not understand that health centre services were free. One respondent stated: “They like to go to private doctors because they do not understand that if they go to a health centre they do not have to pay.” Some of the respondents had received training on migrant issues, including trying to eliminate the practice of begging. One respondent said: “Most of them go west to Phnom Penh and when they return they are in poor health. Ten of them go and only eight return and we don’t know what health problems these people have. They run back and forth. It is not easy being a migrant.” The respondents spoke about some ways in which they helped or felt they could help the migrants. One respondent said: “We provide spiritual support for them, we teach them about migration and we educate them on not begging other people for money. Migration within our country is not a problem, but if they migrate to Thailand or Vietnam it is pretty risky. So it is not like our country. That’s what we explain to them. Being in our country is better.” They went on to say that the migrant workers needed specific trainings so “they can hear and analyse [the topic] themselves”. They suggested providing them with training in communicable diseases, HIV/AIDS and hygiene, and informing them that buying medicines from an unlicensed drug seller may not help them. In terms of reaching migrants, the respondents emphasized educating the families of the migrant workers, who would then share the information.<sup>25</sup>

### **3. Pandemic preparedness**

When asked about serious illnesses that involved many people becoming sick in their villages, one respondent identified an incident when people had diarrhea, stomach

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<sup>25</sup> Refer to footnote 20.

cramps and vomiting, which spread from person to person causing four to five people to get ill. The VHSG respondents assessed the symptoms as being very severe and believed the sick people could die if they were not treated. The respondent stated: “It became severe over a very short period of time.” Most of the patients went to the health centre as they needed oral rehydration solution. The VHSG respondents made the point that some villagers went to the health centre only because the traditional healer would not be able to treat them because they needed intravenous fluids. One respondent said: “Some people strongly believe in superstition. They vomit until they almost die but they still light incense. It takes a lot of time to convince them to come to the health centre.” Other VHSG respondents said there had been recent outbreaks of colds, coughs, measles and chickenpox.

The VHSG respondents said that, when they could, they encouraged people to go to the health centre and sometimes they asked the doctor to visit the patient. Other VHSG respondents then stated, however, that if the patient could not go to the health centre they would go and tell the doctor what the symptoms were and then take the medication to the patient. If there was an illness with symptoms such as diarrhea and vomiting, they would always report the illness to the health centre. It was then stated that those who were ill but did not have money would go to the health centre, while if the patient had money and was seriously ill, they would try to go to Vietnam. All epidemics were reported to the health centre.

When asked about diseases that can spread between communities and countries, respondents knew about HIV/AIDS, avian influenza, SARS, malaria, typhoid, dengue fever, hepatitis and cholera. None of the participants had witnessed an outbreak that

had spread across communities, but most had heard of them. The respondents believed that people who transported poultry across the border were at high risk. Diseases that respondents said they had encountered included diabetes, hepatitis, cirrhosis, cholera, malaria, typhoid and dengue fever. Diseases they felt were a risk in their communities included avian influenza, dengue fever, malaria, SARS and typhoid.

Respondents emphasized the importance of avian influenza prevention, and one respondent stated: “Because we have common borders with other countries, it is possible that the disease can spread. Second, we do not know where the chicken buyers are from. They ride their motorbikes everywhere from one village to another.” The respondents felt that they were prepared for an outbreak of avian influenza and had learned what to do through workshops and media, including the radio. They then disseminated the information to the villages through the coordination of the village chief. They also stated that they had the phone numbers they needed to report an outbreak. One respondent, however, identified a possible barrier to good prevention: “People will prepare themselves only if one or two people die.” While some people know how to prevent avian influenza, some respondents said that they did not practice it, that they thought avian influenza was the same as Newcastle disease,<sup>26</sup> that they compared the two diseases and saw that they had the same signs. Another barrier to prevention that was mentioned was the fact that not everyone attended the education sessions in the villages, and that, while “people are taught how to identify and examine dead birds, why animals die quickly and in large numbers, and recognize symptoms of sick or dead animals, most understand very little”. Another respondent said: “Some know, some don’t know. Some people pay attention to the issue and

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<sup>26</sup> Newcastle disease is a bird disease with symptoms very similar to those of avian influenza.

those whose standard of living is low, do not care.” Other ways through which villagers are educated include bringing them together for a meeting and telling them to do certain things, such as not to eat dead chickens, handing out one bar of soap per household, to wear a mask and to cook the chicken at a high temperature when preparing it, and to bury the feathers. The VHSG respondents also stated that, if many animals had died in their village, they reported the case to the agricultural authorities so they could come to investigate the cause of death.

#### **4. Non-pandemic emergency preparedness**

VHSG participants defined “disaster” as follows: “A disaster is an emergency situation or a problem that happens quickly and unexpectedly. For example a house fire, storm...” They defined “emergency” as follows: “An emergency situation is when there is war or something and older generations would know how to prevent it. They would create scarecrows, ring bells...when an emergency situation arises. I have never seen an emergency event like that.”

Respondents seemed to be very aware of what an emergency was; however, there were differing responses with regard to whether they had been exposed to one or not. Some respondents identified house fires or storms as emergencies, while others said they had never experienced an emergency.

One respondent said the following: “Our village does not yet have a protection system. That is why we are at risk of experiencing disasters. Unlike other countries where there is equipment to catch lightning, in our country there is no such system to control the event.”

Respondents identified flooding and drought as the most common disasters they faced. They stated that there were more droughts than floods and that flooding could happen first with a drought happening afterwards: “Usually there is no rain for several months and then rain starts to fall and can cause flooding to rice paddies...it destroys everything.”

When asked how they prepared for these events, respondents said that they stock foodstuff in advance of the rainy season and, when there is drought, they prepare rice seeds, “light rice”, for seasonal cultivation. They said that the government sometimes helped by providing rice seeds when there was prolonged flooding or drought, and that the Cambodian Red Cross distributed mosquito nets, mats, blankets, bicycles, rice, axes and other small materials, but that this “was not adequate”.

When asked if they felt prepared to address an emergency situation, one respondent said that they needed to be resourceful and find solutions themselves, because even if they reported a problem to the commune authority often, they could not respond in time. ” Another said: “Even when agriculture officials came down to resolve the insect problem, they were unable to resolve everything.” When the village chiefs were asked if they had any disaster response plans in place, one chief said: “In the past we disseminated information to the people in the village and commune. We try to address many things at the same time, including robbery, thefts, drought, insects destroying crops, and so on...if we cannot find any way [to respond] we just use our traditional practices. We also need to alert our people so they can take precautionary measures.”

When asked if they had disaster prevention plans, it was clear that no one had

prevention plans in place: “It is very difficult to have a preparedness plan as we don’t know what is going to happen in advance.” When asked further about how they responded to problems in their villages, the work of local associations was raised as a way to assist people: “In my village when a person dies we have an association for the dead. In terms of firewood [to cremate the body] it is not difficult to manage. We can just ask each household to contribute a piece of firewood.” Another respondent said: “For old people, I also help by giving them some of our money saved. Our village members put their money into a savings box every month. Some contribute 1000 or 2000 riel each month depending on their ability. We inform our members when we need money to help poor or old people or for funerals.” Further responses included calling people to a meeting to educate and disseminate information to them.

## **IV. Conclusions and recommendations**

### **A. Conclusions**

The conclusions detailed below are tentative for the reasons outlined in the limitations section above. They can, however, serve as a guide to (a) future questions, (b) potential issues, (c) capacity building needs and (d) understanding the existing knowledge, practice and gaps that are shared among migrants and the communities they interact with, as well as possible differences between the various migrant groups.

#### **1. Vulnerability of migrant groups**

The FGDs indicate that Cambodian returnees, with their seasonal short-term work in Vietnam, are the most vulnerable migrant group for the following reasons:

- As farmers by profession, their livelihoods can be directly affected by

droughts and floods, insect plagues, storms and animal diseases.

- In the off-season when they are not working in the fields and have nothing to sell or eat from their land, they work as migrant workers in Vietnam, as well as in Phnom Penh. They stated that they felt open to exploitation and that the work was hard. It was clear from the FGDs that this work was, however, a necessity to sustain their families, including putting food on the table.
- Any unexpected expenses, such as those that result from illness, whether of a human, or of animals (leading to the loss of animals), could lead to destitution. Migrant work seems to be a way to (a) provide one's family with some extra money and meet needs during the seasons when there was little income or food from farming available, and (b) try to respond to a financial crisis in a family. The absolute dependency of families on income from migrant work could, however, open the door to exploitation. The less regulated sectors, such as construction and farming (day labourers), seem to be more problematic, while the casinos and garment factories provided better situations for migrant workers.

From the FGDs, it was difficult to gauge the exact level of vulnerability faced by the Vietnamese migrants, but it did indicate that they also faced some of the issues outlined above (see table 3). Tables 1 and 2 indicate that some Vietnamese migrants worked as construction workers, which would indicate that perhaps their work was seasonal as well. The vegetable sellers and traders, however, seemed to be working in Cambodia because of the opportunity of lack of local vegetable sellers and traders, and they did not seem to feel as vulnerable as the Cambodian returnees did in Vietnam.

Both the casino workers and the factory workers stated that they usually send their earnings home and also spend them on self-expenses including living and other basic needs. They seemed to have relocated from villages that were not very far away, although this was not clear from the discussion responses.

Important to an understanding of vulnerability, however, are the level of education, family situation, gender and age of the different migrant groups. Almost all the casino workers were single and in their early to mid twenties with higher levels of education than the other migrant groups. They emphasized that they sent money home to their families and were seeking to gain experiences and skills and to access more education while working. The factory workers were mainly in their mid to late twenties and married, causing them to have slightly greater responsibilities towards their immediate family as well as their parents/siblings. They indicated that the factory was close to their homes and that the environment was good.

The average age of the Vietnamese migrants was late forties to early fifties, and most had families, although there were some widows and widowers, and lower levels of education. The Cambodian returnees were a mix of ages, with the average in their early forties, the majority with either no education or a very low level of education, and families, leaving them perhaps vulnerable to exploitation as they seemed to be able to find jobs only in unregulated sectors. Age and life experience could mean a greater incidence of illness, and greater family responsibilities, which led to the need for a greater income. A lower level of education and possibly less spare time outside of work could lead to less access to information about pandemic preparedness measures and, as discussed in more detail below, could also prevent them from accessing health-care systems when unwell.

## **2. Barriers for migrant groups to seeking treatment for health problems**

All groups identified illness as a potential hazard to their well-being and their and their families' livelihood due to the costs associated with treatment. VHSG respondents also indicated that, for cultural reasons, patients often chose not to access assistance at health centres until they were seriously ill, preferring to try traditional remedies and prayer. In the discussion, the VHSG respondents seemed to be referring to the Cambodian host community, although it is likely that these observations are also pertinent to the Cambodian migrant populations. Both of these issues are potential barriers to pandemic preparedness as people tend not to seek treatment or notify the relevant authorities when they are ill.

Further barriers included poor roads, especially during the rainy season, the poor manners of the doctors towards the patients (impolite, ignore patients) and the lack of medicines at health centres. These are systemic issues that further prevent patients from accessing health systems, reducing the likelihood that health systems can identify a potential disease outbreak. Recommendations by the migrant groups included having doctors available in villages and able to make home visits, medical staff always present at health centres, and good medicines available at the health centres. The Kampong Ro Cambodian returnee group did not make these criticisms, and seemed very happy with their health services. The reason for this could be an area for further investigation.

## **3. Gaps in migrant communities' knowledge of health topics**

The FGDs indicated that, of the migrant groups, the Cambodian returnees had received the most education on a broad range of health topics. The FGDs with VHSGs

further showed the extensive educational work that they, along with the local authority and health centres, conducted by disseminating health education information within their communities. In particular, there seemed to be a high level of understanding of avian influenza transmission and prevention measures among migrant groups and VHSGs. The knowledge of the Cambodian returnees indicates that this work is successful, although the VHSG respondents felt that community members' knowledge could be improved on, particularly of pandemic preparedness. The FGDs with the Vietnamese migrants indicated that they had received education on health, such as exercising, and not drinking or smoking. However, they did not mention any further health messages. It is possible that this has to do with the limitations of the FGD (that is, insufficient probing) or, as would be expected, that they have less access to health education systems.

#### **4. Gaps in migrant communities' understanding of illness and transmission of illness**

In general, there seemed to be an awareness of the illnesses communities experience, but not of how they are transmitted (with the exception of avian influenza). The focus of the FGD questions was avian influenza, and all the migrants were able to describe prevention measures and to identify how it could be transmitted. It was not clear if they understood the link between healthy practices, such as hand washing, and how red-eye disease, typhoid and cholera are spread, or why some of these diseases are more prevalent during times of natural disaster. One Vietnamese migrant made the interesting comment that they did not worry about getting SARS or HIV and, if they did get sick, they would go to Vietnam for treatment. The Vietnamese migrant also stated that they were most worried about cancer and tuberculosis because they could

not be cured. This could indicate that some migrants are not aware of how some of these diseases are contracted and/or transmitted or what the risks and consequences are to them, and are focused on how they would respond rather than on prevention. This again indicates that further education, based on research, targeting these groups could improve pandemic preparedness outcomes.

## **5. Non-pandemic emergency preparedness**

All migrant groups identified flood and drought as emergency events they had experienced. Many had also encountered storms. The government of Cambodia and the Cambodian Red Cross were the key actors in providing assistance. The VHSG respondents felt, however, that their assistance was not adequate. In terms of preparedness measures, the respondents had similar plans, including putting money aside, and having stored rice and other food, medicines and firewood. The factory workers expanded on this and mentioned protection from mosquitoes, and keeping the house and compound clean. In the case of a disease outbreak, however, preparedness measures, as opposed to prevention measures, were not elaborated on by any group. When discussing drought, the VHSG respondents mentioned the planting strategies the villagers engaged in to help them manage this natural disaster. The Vietnamese migrants had the fewest preparedness measures in place, although they were the only group to mention monitoring the media as a preparedness step.

In terms of infrastructure steps that would better prepare communities for disasters, raising houses on stilts and raising the land were identified and practiced by the migrants and VHSGs. They also identified problems with roads and services at health centres as obstacles to accessing health care. Therefore, road conditions, the

preparedness of health clinic staff, including enough supplies of medicines, and enough staff and funds for village outreach, are issues to be looked into further.

The Cambodian returnees were the only group to mention a strategy through which they would generate money to put aside in case of an emergency. With the exception of this one Cambodian returnee focus group, it is unclear if the plans the migrant groups have in place have been implemented or are only ideas. If these are steps that have in fact been implemented, it remains unclear if they are implemented only after a warning or some indication that there may be an upcoming disaster, or if they are part of their daily and/or yearly plans.

The VHSG respondents faced potential planning obstacles, and cited difficulty in bringing people together for information sessions as the primary obstacle in doing their work. They further emphasized that, when disasters occurred, they felt that they had to be resourceful and find solutions themselves, by either looking for new creative solutions or using traditional practices, as government responses were often too slow or unable to respond to the problem at all. This indicates a perceived and actual gap between the response planning and the capabilities of the external agencies and/or the government to meet the needs of the local people. In general, the VHSG respondents did not have a formal plan or preparedness measures in place and stated that it was difficult to have a preparedness plan when one did not know what was going to happen in advance. This indicates the need for further training in the reasons for emergency planning for these key actors in preparedness and response delivery. The VHSG respondents demonstrated their solutions and response-orientated thinking as they began to explore the possibility of using existing village-based associations as a way to assist people.

## **6. Barriers to VHSGs working with migrant communities**

The VHSG respondents indicated that the transient nature of migrants led to their poorer health as they lived in more vulnerable conditions, which, from the voices of the migrants themselves, could be representative of situations the Vietnamese and internal Cambodian migrants face, and what the Cambodian returnees experience when working in Vietnam. The VHSG respondents also indicated that, if migrants became seriously ill, they would seek treatment in Vietnam (it is fairly common for Cambodians who have the ability, to seek medical treatment in Vietnam due to the perceived superior health system at a reasonable cost). It was not clear which specific migrant groups the VHSG respondents were speaking of, although all migrant groups, with the exception of the Vietnamese migrants, stated that the health centres were one place they would seek medical assistance. It was further stated that the option of seeking assistance at a hospital in Vietnam required money. The VHSG respondents seemed to say that they felt these migrant groups needed training on where they could access health-care services and when it was sensible for them to do so. One respondent made the following comment: “In my area there are lots of factories, casinos, so it is very appealing to the migrants. We are not sure if the migrant workers from different areas are healthy...it is just like a chicken, when we see it walking we do not know if it is sick or not.” This indicates the need to develop more strategies to access migrant workers in order to assess their state of health, which could also be used as a training opportunity and could be one way to address barriers to accessing migrant groups. Strategies proposed by VHSGs focused on educating the migrants’ family members, who would in turn educate the migrants. A concern, however, is that the Vietnamese migrants and the casino workers did not indicate that they learned about health topics from family members. There was no discussion of whether there

were any existing medical screening processes (except in background documents); for example, the factory workers refer to a factory doctor, but it is not clear if they are required to have a medical check-up before working at the factory, and if they did, if that information was shared with the Cambodian health authorities. It is also unclear if VHSGs or health centres have any plans or abilities to reach out to migrants, which might prove useful in improving migrants' access to health services.

## **B. Recommendations**

1. Undertake FGDs with Cambodian migrants<sup>27</sup> in Vietnam when they are doing seasonal work, and run similar FGDs with the Vietnamese local authority and health workers. Discussion points could include how the Vietnamese village-level health-care workers at hospitals feel about Cambodians seeking treatment there (both migrant and non-migrant), and what systems and practices are in place and could be improved to better (a) survey health issues, (b) identify and respond to potential outbreaks, (c) develop prevention actions that target both Cambodian medical visitors and migrant workers accessing Vietnamese health systems and engaging in trade activities that could spread diseases, and (d) improve the access of the vulnerable Cambodian migrant workers to these systems.

Further research could also include FGDs with Vietnamese returnees in Vietnam in order to better gauge the reasons they work as traders or travel to Cambodia as day labourers for other types of work. This would help in better understanding their level of vulnerability, and which Vietnamese systems they access to learn about preparedness measures and health education topics.

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<sup>27</sup> In December 2008, IOM conducted an FGD and a KAPB survey in Tay Ninh in collaboration with government partners. The results of both the Svay Rieng and the Tay Ninh situation analyses will be shared with Cambodian and Vietnamese government counterparts and other stakeholders.

2. Ensure that both a gender and an ageing analysis of the future work of the Project is incorporated into all aspects of programming. This would lead to gender- and age-appropriate planning and consultative processes, and activities and strategies that capture (a) how knowledge and information is gained by women and men, youths and the elderly, (b) their respective roles in prevention measures, (c) their respective roles in preparation planning, (d) their respective risks and vulnerabilities to illness and in emergencies, and (e) the responsibilities of women, men, youth and elderly in emergencies both in the family and in their communities.

3. Design strategic approaches to disseminate information appropriate to the age, gender, workplace, culture and language of the migrants in order to raise their awareness and to stress the importance of pandemic preparedness planning and response.

4. Conduct further training for migrant groups on prevention measures and how pandemic preparedness planning can mitigate their impact.

5. Address priority infrastructure and multi-system issues that would have an important impact on the well-being of migrant communities in times of emergency. Key areas identified by migrant groups are as follows: (a) having better public health system functioning, including medicines available at health centres/clinics, and increasing the number of health-care staff and the quality of patient care; (b) improving roads and (c) improving houses so that they are raised above water levels.

6. Continue to inform migrant groups about the services offered at health centres. A

question is whether migrants are able to access free health services, particularly Vietnamese migrants as Vietnamese nationals in Cambodia, and Cambodian migrants in Vietnam.

7. Look at the role of private health-care clinics/hospitals and how to incorporate these providers into pandemic preparedness planning. Conduct an FGD with private health-care providers similar to the one conducted with VHSGs, based on information that migrants also access health care at private health clinics/hospitals.

8. Conduct further research into actual planning processes in place in migrant communities in order to determine if their preparedness measures are part of annual planning and/or are put into action only after an indication that there may be a possible disaster. Further explore (a) whether current planning would meet the needs of the community after a range of disaster situations and (b) how external agencies could best support and supplement these plans.

9. Identify ways to integrate traditional health practices into pandemic preparedness plans and to link the traditional healers and religious leaders through training and their participation in formal planning structures into preparedness planning and response activities.

10. Develop strategies to better enable VHSG members to bring together village members and migrant groups and thus to plan for and develop pandemic preparedness measures. The VHSG respondents proposed having snacks as an incentive to encourage them to attend; however, within the scope of preparedness steps it is likely that other incentives can be found to encourage migrants to engage in these steps.

11. Strengthen the health sector's ability to respond to VHSG requests for assistance so that they feel they are receiving the support they need to do their work, and improve communication channels in both directions. Identify in greater detail which common requests from the VHSG need responses from the health centre, and identify the health centre's requests of area health officials, and the reasons for the delay in response.

12. Build on the experience and information gained during the FGDs, which gave the migrant communities a forum to contribute to the development of pandemic preparedness strategies. This can be done by identifying other targeted ways migrant representatives (both women and men) can continue to participate in and, when appropriate, take the lead in the process of planning these strategies.

13. Further develop existing strategies (for example, IOM returnee health assessments) to map and respond to the health status of migrant communities.

14. Conduct further training with VHSG members in preparedness and response delivery, addressing the purpose for pandemic and non-pandemic emergency planning. Further explore with these key actors, as well as with village and commune chiefs (those who are not members of VHSGs), other key local authorities, representatives of migrants and local villagers (including men, women, youth and the elderly), traditional healers and monks, what structures currently exist within villages and migrant community groups that could be harnessed to develop better preparedness and prevention measures. The VHSG respondents demonstrated their solutions and response-orientated thinking as they began to explore the possibility of using existing

village-based associations as a way to assist people.

15. It would be worthwhile to know what the responsibility of factory and casino managers is towards their migrant staff in times of emergency and what measures currently exist or could be put in place as part of a wider preparedness and prevention plan. It would also be useful to know what risks factory workers and casino workers face, and what preparedness measures should focus on.

16. Conduct further research into the attitudes and behaviours of host communities in Vietnam and Cambodia towards migrants so this information can be used in developing pandemic preparedness measures and interventions that specifically address the needs of migrant groups. Ensure that all future strategies and activities assess the potential for creating stigma and discrimination against migrant workers. Where needed, incorporate mitigation strategies, especially when implementing activities that may single out migrants, such as health assessments.

## V. Annexes

### Annex 1: FGD Guideline Questions with Migrants

#### GUIDELINE QUESTIONS FOCUS GROUP DISCUSSION WITH MIGRANTS

##### INTRODUCTION

*Thank you for coming here to speak with us today. We are from an organization called IOM that works in many countries to help people like you, who travel away from home to find work.*

*We would like to ask you some questions about this kind of life and the work that you do. We also want to ask you some questions about healthcare and other kinds of support that you may or may not receive and concerns that you may have.*

*This is a discussion, so you do not have to answer all of the questions. There are no right or wrong answers so please feel free to just talk about what you think or feel, even if it's different from what others say. I'm interested in all of your ideas whether positive or negative.*

*I am here to ask questions, listen, and make sure everyone has a chance to speak. We have a lot to discuss, so I may change the subject to move onto to a new question.*

*Anything that you tell us will be used only by our organization. We will not write down your names, so no one will know who you are. So please feel relaxed and free to talk openly.*

*Knowing this information will help us to plan better programs to help you and others like you who travel to find work.*

##### WARM-UP

*(Lets begin by chatting about what you do in your free time.)*

- Please tell me what are some things you do when you are not working?
- And what is your living situation like? Where do you live and whom do you live with?

##### WORK

*(Now I'd like to ask you some questions about your work.)*

- What kind of work you do, and how long have you been doing this job?
- What do you like about this kind of work?
- What do you dislike about it?
- What do you do with the money you earn?
- Why did you decide to go to [Svay Rieng / Vietnam] to do this kind of work?

##### HELP-SEEKING BEHAVIOR

*(Ok, now I'd like to talk to you about what kinds of problems you may have and how you get help.)*

- What are the most important problems or concerns you have faced in your life over the past year?
- Whom do you usually talk to about your problems?
- If you were to get into trouble, to whom would you go for help? What kind of trouble do you fear getting into?

- Where do you usually get information? About news? About health education?
- Tell me about any health education that you have received. What did it teach you? Was this information useful? Why or why not?
- What do you think is the best way to provide health education to people like you, who travel away from home to find work?

### **ACCESS TO HEALTH CARE**

- What do you usually do when you feel sick? When do you decide to seek help? Where do you go to get help? Who do you see?
- Think about the last time you went to a health center or saw a doctor or nurse. Please tell me about your experience. Was it useful? Why or why not? Where you treated well? Did you have any difficulties getting treatment?
- Tell me about any problems you may have with getting health care.
- How do you think getting healthcare can be made easier for you?
- What do you do to stay healthy?
- How did you learn to do that?

### **PANDEMIC PREPAREDNESS**

*(I'd now like us to talk about big health problems and other bad situations that can affect a lot of people at the same time.)*

- What illnesses do you feel are very common?
- Which ones are the most serious? Why?
- Sometimes a lot of people in one community get sick with the same illness. If you have ever seen this happen in a community where you've lived, tell me about it. What illness did the people get? Did they get better? What kind of help did they receive (from whom)?
- Some illnesses spread to a lot of communities and even to different countries around the world. Have you heard of any illness like this? Which ones? Have you heard about bird flu? SARS? AIDS? Malaria? Dengue?
- Do you feel worried that you or your loved ones could get sick with any of those illnesses? Why or why not?

*(Let's talk about one of those illnesses – bird flu:)*

- Do you know how to prevent the spread of bird flu? Please tell me what you know.
- Who taught you that information?
- If an illness like bird flu was making many people sick, what would you do to protect yourself? Who do you think would be able to help?

### **OTHER EMERGENCIES**

- When you think of an “emergency” situation, what comes to mind?
- What emergencies do you think you are most likely to encounter? Why?
- Have you ever experienced a natural disaster such as a flood or drought, or other serious situation that caused hardship for a lot of people at the same time? Please tell me about it. What did you do to help yourself? What kind of help was available to you?



## **Annex 2: FGD Guideline Questions with VHSGs**

### **GUIDELINE QUESTIONS FOCUS GROUP DISCUSSION WITH VILLAGE HEALTH SUPPORT GROUPS**

#### **INTRODUCTION**

*Thank you for coming here to speak with us today. We are from an organization called IOM that works in many countries to help migrants.*

*We would like to ask you some questions about the work that you do, what kinds of support that you may or may not receive in your work and any concerns that you may have.*

*This is a discussion, so you do not have to answer all of the questions. There are no right or wrong answers so please feel free to just talk about what you think or feel, even if it's different from what others say. I'm interested in all of your opinions whether positive or negative.*

*I am here to ask questions, listen, and make sure everyone has a chance to speak. We have a lot to discuss, so I may change the subject to move onto to a new question.*

*Anything that you tell us will be used only by our organization. We will not write your names down in any reports, so no one will know what you said. So please feel relaxed and free to talk openly.*

*Knowing this information will help us to plan better programs to help you and the people that you work to help.*

#### **WARM-UP**

*Lets begin by introducing ourselves. Please tell us your name and where you live.*

#### **WORK**

*(I'd now like to ask you some questions about your work.)*

- What responsibilities do you have in the village/commune? Describe how you help people?
- What kind of training have you received? Was it useful for the work that you do? Why or why not?
- What other kind of training or resources do you think would be useful for your work?
- What problems do you face in your work?
- Who are your main government contacts? When and how often do you see them? Do you feel that you get enough support from your government contacts to do your work?

#### **HELP-GIVING BEHAVIOR**

- What do you think are the most important problems affecting people in your community? Non health problems? Health problems/illnesses?
- Do you feel able to help people with these problems? Why or why not?
- When educating people about health, what kinds of materials have you found most useful? Which ones have not been useful? Please explain.

*(Think about people who leave their homes to travel to Svay Rieng or to Vietnam to find work. We call them migrants.)*

- Do you ever meet with migrants for your work?
- What important or special health problems do you feel that they have?
- Do you think that they can easily get help when they are sick? Why or why not?
- Have you received any special training for helping migrants?{
- Do you have any suggestions for ways to help migrants?
- What kind of special support or training do you need in order to help migrants?

### **PANDEMIC PREPAREDNESS**

- Have you ever seen an outbreak of illness in your community, where a lot of people got sick with the same illness at the same time? Tell me about it and how people coped with it. What illness? How serious was it? What help was available to them? Did you help them or the community during this time? How?
- If you heard or saw that there was an outbreak of illness in your community today, to whom would you report it?
- Some illnesses spread to a lot of communities and even to many countries around the world. Have you heard of any illnesses like this? Which ones? (probe: Bird flu? SARS? Dengue? AIDS? Malaria?)
- Which of those illnesses do you think people in your community are most likely to encounter? Why?

*Lets talk about one of those illnesses – bird flu.*

- If there was an outbreak of bird flu in your community, do you feel that you are prepared to cope with it? Why or why not?
- Do you know how to prevent the spread of bird flu?
- Do you think others in the community know how to protect themselves and their animals from catching bird flu?
- What is the best way to educate people in your community on how to prevent illness?

### **OTHER EMERGENCIES**

- When you think of the word “emergency” what comes to mind?
- Other than illnesses, what kinds of emergencies do you think people in your community are most likely to encounter? Why?
- Have you ever experienced a natural disaster such as a flood, drought, or other serious situation that caused hardship for a lot of people at the same time? Please tell me about it? What did you do to protect yourself and your loved ones? What kind of help was available to you and others who were affected?
- As a commune worker do you feel well-prepared to help people if an emergency were to occur? Why or why not?

- What ideas do you have to help people become better-prepared to deal with big health problems or other emergencies?

**CLOSING**

- Is there anything else that you would like to tell me or talk about before we end our discussion?

*(Thank you for coming here to talk to us today. It has been very interesting and useful.)*

**FOCUS GROUP PARTICIPANT INFORMATION**

**Moderator:** \_\_\_\_\_

**Commune Health Workers**

Participant Name	Sex	Age	Marital Status	Education Level completed	Commune
1	M / F				
2	M / F				
3	M / F				
4	M / F				
5	M / F				
6	M / F				
7	M / F				
8	M / F				
9	M / F				
10	M / F				

### Annex 3: FGD Training of Moderators

#### Focus Group Discussion Training of Moderators

Svay Rieng, 17 September 2008

**Trainers:** Phiev Khay, Kha Serey, Nuth Sam Ol

**Participants:** 9 DSVY staff, 2 DoLVT staff, 2 DOH staff

**Objective:** To provide participants with skills for conducting focus group discussions and skills for taking notes of the focus group discussions, so that they will be able to collect information from respondents on health access, help seeking/giving behavior, their knowledge and their behavior related to preparedness for a pandemic or an emergency.

Time	Contents	Facilitator
8.00	Welcome and introduction	All
8.10	Presentation of the objective of the training	Khay
Focus Group Discussion		
8.25	Introduction to terms: pandemics, emergencies, preparedness, health access, help seeking/giving behaviour	Khay
8.45	Brainstorming <ul style="list-style-type: none"><li>– What is focus group discussion?</li><li>– Why use focus group discussion?</li></ul>	Khay
9.10	Group work discussion <ul style="list-style-type: none"><li>– Necessary skills for an FGD moderator.</li><li>– Characteristics of an FGD moderator.</li></ul> Presentation	Khay
10.00	Morning tea break	All
10.15	Pair work discussion <ul style="list-style-type: none"><li>– Skills for note taking for an FGD.</li></ul>	Khay
FGD Guideline Questions		
10.50	FGD Guideline Questions review and clarification	Serey
12.00	Lunch break	All
Focus Group Discussion Practice		
2.00	Practice 1: Role play	Sam Ol
3.30	Afternoon tea break	All
3.45	Practice 2: Role play	Sam Ol
5.00	Training finished	All

## **Annex 4: Report on FGD Activities**

### **REPORT ON FOCUS GROUP DISCUSSIONS ACTIVITIES FOR PANDEMIC PREPAREDNESS FOR MIGRANTS AND HOST COMMUNITY PROJECT**

As part of the situational analysis in Svay Rieng on knowledge, attitude, behavior, and practice regarding the preparedness for pandemics and responses to emergencies, the Pandemic Preparedness for Migrants and Host Communities Project launched a series of focus group discussions (FGD) with some selected categories of respondents including key migrant groups and community health workers within some selected areas along the border of Svay Rieng.

The analyzed data obtained from the FGD activities will be used to design further interventions for the Project to strengthen the capacity of migrants and receiving communities, district and provincial health and non-health sectors to cope with pandemics or other crises. The project activities will include:

- Increase capacity for community based surveillance, prevention, home based management of communicable diseases (including influenza like illnesses) and social well-being of migrants and receiving communities in the event of a pandemic or other crisis.
- Conduct pandemic preparedness information and social mobilization activities for migrants and receiving communities, civil society and border control agencies
- Strengthen capacity, particularly at the district and commune level, to respond to the needs of migrants in disaster preparedness and pandemic contingency plans

Below are the details of the whole process of the FGD activities:

#### **A. TRAINING OF TRAINERS**

A half-day Focus Group Discussion TOT was conducted in Svay Rieng by an IOM consultant Nicole Umemoto to three IOM staff including two project assistants (Kha Serey and Nuth Sam Ol) and one national project officer (Phiev Khay). The training focused on:

- Terms including Emergencies and Pandemics
- Why FGD is used.
- How to select participants and where to conduct an FGD.
- Skills required for and FGD moderator.
- What an moderator should and should not do during an FGD.
- How to take notes of an FGD and how to write up a full note of an FGD.
- How to use Guideline Questions

#### **B. TRAINING OF FGD MODERATOR AND NOTE TAKERS**

The three IOM FGD trainers developed a curriculum (Annex 1) and conducted a one-day Focus Group Discussion Training at the IOM/DSVY Project Office on 17<sup>th</sup>

September 2008 to 13 participants, of whom nine were from the Department of Social Affairs, Veterans and Youth Rehabilitation (DSVY), two from the Department of Health (DOH), and the other two were from the Department of Labor and Vocational Training (DoLVT). The training was aimed to not just provide skills for conducting focus group discussion and taking notes, but also to familiarize participants with the Guideline Questions for Migrants (Annex 2) and Guideline Questions for Village Health Support Groups (Annex 3). The training started with the focus on the skills and characteristics of a moderator and a note taker, followed with the review of Guideline Questions and finished with practices using role play for an FGD.

#### **SELECTION OF FGD RESPONDENTS, DATES AND LOCATIONS**

By the end of the FGD training, a clear plan was developed for all the trainees to conduct FGD in Svay Rieng with 5 different categories of respondents. They are:

##### **1. The Cambodian returnees**

The Cambodian returnees who were assisted to return from VN to Cambodia as irregular migrants and also some of whom are the parents of trafficking victim returnees were selected by the DSVY case workers for FGD on 12<sup>th</sup> September 2008. The participants were a mixture of women and men. They were divided into two different groups and held in two different locations – one group in Teng Mao village of Chantrea district and the other in Kandal village of Kompong Ro district. The Teng Mao FGD was conducted in the morning and the Kandal FGD was held in the afternoon.

##### **2. The Village Health Support Groups (VHSG)**

The VHSG and village chiefs who participated in the IEC training were also invited by DOH to participate in the FGD. Two different FGD were held in Mesor Tngork in Chantrea District on two different mornings by staff from DOH and DSVY. One FGD was conducted on 17<sup>th</sup> while the other was organized on 20<sup>th</sup> September 2008.

##### **3. The garment factory workers**

The FGD with the factory workers was arranged on 23<sup>rd</sup> September 2008 through the DoLVT at the Cambodian Garment Factory which is situated along the national road about 10 km from the Bavet border. It was jointly conducted by IOM, DSVY and DoLVT with two different groups in two different sessions. The morning session was held with the female workers and the afternoon session was organized with the male workers.

##### **4. The Vietnamese migrants**

The Vietnamese migrants who had been living and doing trading in Svay Rieng for long were one of the target groups to be selected for FGD. The interviews with this category were conducted by DSVY case workers on 24<sup>th</sup> September 2008 in two different sessions (morning and afternoon) and in two different locations. Both sessions consisted of both male and female participants. The morning session was held in Ta Beb village of Bavet commune while the afternoon session took place in Po village in Mesor Tngork commune, Chantrea.

##### **5. The casino workers**

The Las Vegas Sun Casino at the Bavet International Border was selected by the DoLVT to have the FGD undertaken with the Cambodian workers on 25<sup>th</sup> September 2008. The FGD was jointly conducted by staff from DoLVT and DSVY with one group of female and one group of male staff. The female FGD was held during the morning while the male FGD was conducted during the afternoon of the day.

## **CONCLUSION**

A reflection session was organized on 17<sup>th</sup> October 2008 by IOM with all the FGD moderators and note takers from DSVY, DoLVT, and DOH. The purpose of the meeting was to reflect on their experiences, impressions and observations of the respondents' participation in the FGD. It was clearly agreed that the FGD with all the five categories of respondents were conducted in an entirely voluntary and participatory approach. All the participants/respondents were relaxed and enthusiastic to share answers and ideas. Please note that after each FGD session, feedback was always done with the moderators and note takers to reflect on their experience about what they felt they had done well, what they were not confident about and why as well as potential solutions or strategies which was very helpful along the way. As a result, in addition to the increase in the knowledge acquired about the communities especially in terms of whether or not they are familiar with preparedness and responses to an emergency or pandemic, the moderators and note takers also manifested the development of more confidence and enthusiasm in carrying out such activities with the community and migrants.

More importantly, it was also noticed that the FGD activities not only collected information about, but also seemingly have given to the respondents as well as the moderators who had never had such experiences before some reflection, stimulation or introduction regarding prevention, preparedness and responses to an emergency, a pandemic or an epidemic such as avian flu, common cold, flu, diarrhea, cholera, dengue fever, conjunctivitis, flood, drought, etc which were mentioned during the sessions. (Please see Annex 4 for the moderators' reflection.)

## Annex 5: Moderators' Reflection

### Moderators' Reflection

A representative moderator said: *“When we started the first session of FGD, we were a bit nervous. We were not very confident as the topics were quite new to us plus we did not seem to have remembered all the questions. We had to look at the questionnaire time and time again and almost just reading out the questions. The respondents seemed to be quite distracted by this and sometimes they found it difficult to understand the question. So we ended up reading out the question again slowly or explaining it or sometimes the trainer just helped with the simplification. During the training, we felt we understood the whole questionnaire, but we found ourselves not understanding the concept of certain questions when we started to read them out. The reflection sessions by the trainers after the actual FGD were very helpful. We really appreciated the additional demonstrations by the trainers. We not only improved techniques, but also became clearer with the topics. We found ourselves conducting FGD in other sessions in a more and more confident and fluent manner. We found it enjoyable.”*

Another moderator added: *“The FGD was a very interesting experience. We learnt more about the different groups of population and especially with regard to the new topics from the questionnaire.”*

A DSVY moderator from Kompong Ro said: *“Amongst the Cambodian returnees who came for the FGD, some of them are my clients. They are very poor. There is nothing in their home. In response to the question “What do you do to stay healthy?”, some said: “I drink boiled water, eat cleaned food, wash hands with soap or firewood ash after toilet, wear a mask, keeping the house clean both outside and inside.” As far as I know, their health and hygiene practice is very poor. They don't have a toilet or even a latrine. They just use the bushes behind their home as toilet. They never wash hands with soap or ash as they have neither soap nor access to clean water. They have no masks. Maybe they just repeat what they had heard to you or maybe the term ‘Healthy’ were making them think of what they had heard.”*

A DSVY moderator from Svay Rieng said: *“I noticed that the poor in the community usually eat sick or dying chicken. The better-off families would even give their sick or dying chicken to the poor and the poor would eat it. When asked what they would do to protect themselves and their loved ones from bird flu when it was making a lot of people sick, I was surprised to hear them say something like making sure their children did not stay near or touch sick or dead poultry, keeping their children playing in distance from infected families, wearing masks, not eating sick or dead poultry, go to health centre for advice, etc. They seemed to know how to protect themselves, but prevention practice for themselves when it has not happened is not in place.”*

Another moderator from Kompong Ro District said: *“When asked: “Have you made any plans to help yourself or your loved ones in case there is an outbreak of a serious illness or a natural disaster?” Some said yes, some said no. Making plans for families in general is not very practical in the community. Even my family is not practising making plans for anything like that. It was interesting to hear them say: “I keep some medicines at home for cold, flu, diarrhea.” “I keep mosquitoes out and set aside some money to send my family to hospital for dengue fever.” “I keep firewood off the ground for flooding.” “I make a well for family and crops during drought.” I feel that*

*the FGD just made them think about what they were saying which may be very useful for them. Honestly speaking, through asking people about these topics about Pandemic, Planning, Emergency, .I myself also have learnt that I should do something for the preparedness for and planning for responding to a pandemic, or an outbreak of a particular serious illness, a crisis or an emergency.”*