

Part 1: KAPB Survey



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Executive Summary

This survey, conducted between April and December 2008, was one of the activities in the program entitled “Pandemic Preparedness for Migrants and Host Communities Project”.

Primary aims were selected as the following.

1. Provide background information for local authorities and other stakeholders, including the provincial disaster management committee, in order to facilitate a migrant inclusive pandemic preparedness plan at the community level.
2. Create a profile of migrants in selected Svay Rieng areas including their mobility patterns; access to health and social services, their knowledge of the pandemic concept and attitude towards it, level of preparedness or general feeling on their ability to cope with a pandemic or any other crisis;
3. Develop a programme to strengthen the migrant and host communities’ capacities regarding emergency preparedness at the community level.

The study featured 830 individual interviews during September and October 2008 in two districts of Chantrea and Svay Teap in Svay Rieng province. The respondents consisted of migrants employed within the formal sector (garment factories and casinos) and others considered as the informal sector (Cambodian returnees and Vietnamese migrants in Cambodia).

Svay Rieng province was selected because the Cambodia-Vietnam cross-border region, due to limited cross border health programme funding, is particularly vulnerable in comparison with areas of Cambodia bordering with Thailand and Lao PDR. In addition, IOM maintains a

sub-office in Svay Rieng conducting a project on human trafficking that identified a number of active cross-border migrant communities in Svay Rieng and Tay Ninh.

The KAPB Survey was complemented by a qualitative study whose findings will be correlated within the analysis of the quantitative data.

Demography

About two-thirds of the respondents were female and those tended to be younger, with 40 per cent of them within the 21-30 age group and 70 per cent of all respondents who were younger than 20 years were female. More than half (56%) of the respondents were married, with 70 per cent of them being female, while of the 30 per cent who were single, the proportion of females to males was only 55 to 45 per cent. Migrants of the formal sectors (garment factories and casinos) tended to have fewer children than the other respondents. 30 per cent of the respondents reached (at least started) primary school while another 25 per cent reached the high school level but only half of them completed those schools. 16 per cent of the respondents did not receive any formal schooling at all, 88 per cent of whom were females.

Mobility and Migration

A majority of the respondents from Tay Ninh in Vietnam (67%) and nearly half of those from Svay Rieng in Cambodia (47%) were born in the cross-border area. Other Cambodian respondents came from 17 other provinces while the Vietnamese respondents were from 26 other provinces of their respective countries. The most common reason cited for migrating was economic; respondents wanted to earn more money and get better jobs.

70 per cent of the respondents (63 per cent of them were female) worked in Svay Rieng throughout the year, while 10 per cent of the respondents classified themselves as seasonal workers, (76 per cent of them were female). 9 out of 10 of the seasonal workers went back to their home provinces when there was no work in the study sites. Migrants working in the formal sector returned to their home provinces 3-12 times a year while those in the informal sector were returning home daily.

Female migrants were more likely to live with relatives on their work sites while male migrants, tended to live with co-workers. Vietnamese migrants were more likely to live alone than Cambodians.

Pandemic and Emergency Preparedness

Most of the respondents were aware of diseases that can spread to communities and stated HIV/AIDS and avian influenza as the most common. About 8 out of 10 respondents were worried that either they or their loved ones would be infected by these diseases. Those who were not worried said it was because they protected themselves, they were not exposed to it and they were healthy and strong.

Migrants working in the formal sector stated that their initial response to an outbreak of disease would be to seek medical help indicating an awareness of or access to medical services and facilities, and/or have the resources to seek private health care services. Meanwhile, migrants in the informal sector said they would stockpile (store) medicines first, illustrating that they are accustomed to undertaking actions that are self-initiated, rather than provider-initiated.

9 out of 10 respondents agreed it was good to plan for an emergency. However, only 60 per cent of the Cambodians and 46 per cent of the Vietnamese migrants have made concrete plans, such as stockpiling food and water, putting aside money and preparing for an evacuation. In the case of an actual emergency, the most common reaction would be to evacuate.

The migrants identified the local government, health services, police and emergency services as the authorities to contact during a disease outbreak or natural disaster. The provision of food, shelter, medicines, money and early warnings were reported to be the most practical ways the government could assist during an emergency.

Access to Health Information

Television, radio, and newspapers were cited as the most reliable sources of news and information., Television, radio and physicians were listed as the best sources for health information. The very low ranking of health workers and information, education and communication (IEC) materials indicates that service providers rarely reach migrants at the study sites. The mobile and transient nature of migrants certainly contributes to this.

Television was also the most-widely used form of media, with more than half of each migrant group saying they watch it daily. Other than the Vietnamese migrants who work in the formal sector, the respondents said they listen to the radio daily. Most of the Vietnamese migrants working in the informal sector and Cambodian returnees do not read newspapers at all.

There is very low coverage of health education activities among migrants in both the formal and informal sectors with approximately 7 in 10 respondents reporting they did not receive

such education/information last year. Of those who received it, around two-thirds were provided by companies and NGOs. Health/medical staff, community officials and village health workers conducted about 20 per cent of the education sessions.

Language, such as mother tongue, and literacy and comprehension levels of the migrants was the most commonly identified barrier to receiving health information. Lack of interest was reported to be another barrier.

Health-seeking Behaviour

A very high proportion of migrants believe that hygiene is the key to maintaining good health. 94 per cent of the respondents claimed they washed their hands before eating while around 63 per cent said they used soap when washing their hands.

There is a relatively high level of awareness of how to prevent the spread of diseases transmitted through droplet infection. The two most common procedures mentioned were washing one's hands after coming in contact with an infected person and avoiding close contact with an infected person.

65 per cent of the respondents said they would go to a government hospital if they felt sick but migrants in the formal sector preferred seeing private physicians. Based on the focus group discussions, Cambodians tended to seek health care at local health centres only when they were seriously ill.

With the exception of the Cambodian returnees, the respondents chose trust as the biggest factor for their selection of service providers/facilities to utilize when they became sick. The Cambodian returnees selected the more practical reasons of cost and location.

Migrants working in the formal sector were more likely to have sought health care compared to those in the informal sector primarily because they had better access to health services. About half of the Vietnamese migrants in the informal sector did not seek any health care last year compared to 23 per cent for Cambodian returnees during the same period. Most of the Cambodian returnees (41%), in fact, sought health care 2-3 times last year. The main challenge in this area is accessibility to services. The Cambodian returnees, being self-employed, do not have readily available access to health services that employees of organizations have. However, their awareness of health service providers and facilities in their communities enable them to seek health care when needed.

The five most popular answers to places the respondents would go if sick were: (1) government hospital, (2) government health centre, (3) private doctor, (4) pharmacy and (5) private clinic.

However, the five most common responses to actual treatment sought during the past 12 months were (1) pharmacy, (2) government hospital, (3) government health centre, (4) private doctor and (5) relatives. This signifies a high tendency among the respondents to practice self-medication, regardless of migrant group. The high ranking of relatives reinforces this point. Self-medication also includes asking relatives what medicines to take when feeling ill because of the inaccessibility to physicians, lack of money and low levels of trust in public health facilities.

Economics determines the migrants' access to health services. Getting money for treatment was the most cited barrier among the Cambodian respondents and the second most cited barrier among the Vietnamese respondents. Another economic factor—fear of loss of income, was also prominently mentioned among all migrant groups.

Many migrants in the formal sector found it difficult to visit service facilities due to inconvenient operating hours. The irregular hours and weekly or monthly rotations of casino and garment workers do not coincide with the opening hours of many public and private sector health facilities. The fact that pharmacies are open longer than health facilities may be a key factor behind their popularity.

Avian Influenza

The survey found that respondents had a high level of awareness of avian influenza but held a lot of misconceptions about the disease. Some of the recommended actions to be taken to prevent avian influenza were among the least stated answers. The perception of risk is also very low.

The following **recommendations** are being proposed:

1. Although there is awareness of emergency preparedness among migrants, concepts about pandemic preparedness must be properly clarified and disseminated among migrants, the host communities, including service providers, stakeholders, gatekeepers and community leaders. This can be done through an extensive information campaign to disseminate information, organizing community forums on pandemic preparedness and fostering a learning environment within government agencies and personnel on pandemic preparedness and related issues

2. The awareness of avian influenza among the migrants needs to be translated into a deeper comprehension of what the disease is—its nature, its risks, its prevention—and turning this into practical actions, all in the context of pandemic preparedness.
3. Age is a key factor to take into account when developing the messages and determining and planning the range of communication activities that will be used in disseminating these messages to each migrant group. Therefore, messages directed at younger and single migrants might focus on their personal well-being while messages targeting older and married migrants might emphasize the health of families as a whole.
4. The television, radio and print media are potentially the most effective channels of information dissemination to the migrants. However, differing levels of media consumption among migrant groups will require distinct multi media strategies and activities to ensure maximum coverage and effectiveness.
5. Personal networks are very important elements in terms of communication activities which should be utilised within this programme as excellent entry points for information and messages. Despite the risk of diminishing accuracy as messages travel within them, they are still invaluable in terms of generating interest and awareness, which could lead to knowledge and behavioural change.
6. When developing educational materials and activities, the varied levels of literacy of the migrants, along with their language skills and their access to mass media must be given utmost consideration.

7. Encouraging migrants to pay more attention to their health is another challenge that can hopefully be addressed through educational activities about health risks and the consequences of a pandemic influenza event, or the importance of preparing for a pandemic.

8. Another significant health-seeking behaviour that warrants attention is self-medication. Although it may not seem to be closely related to concepts related to pandemic preparedness, self-medication has long-term effects on the perceptions of health and on people's health in general. This will, in turn, have positive effects on the health-related initiatives in relation to pandemic preparedness.

9. Health education activities with migrants should also be mindful and sensitive to their non-health concerns like income, family dynamics that lead to certain situations, employment and security, among others.

I. Introduction

A. Overview of Cross-border and Internal Migration in Cambodia¹

Table 1. Cambodia Development Indicators

Population, 2007 (in 1,000)	14,364
Population growth rate, 2007 (%)	2.0
Growth rate of population aged 15-39 years, 2005-2010 (%)	2.93
Total fertility rate, 2007	3.4
Percentage urban, 2007	21.0
Net migration rate, 2005 (per 1,000)	0.1
Per capita GDP, 2006 (at current prices in US Dollars)	327.67

As in most other countries, migration and economics in Cambodia are closely interrelated. The country's median age is 21.3 years, with approximately 60 per cent of the population under the age of 25. Thus, Cambodia has a high fertility rate which will likely entail a significant increase in population growth in the future. This presents a challenge in creating employment for its growing workforce.

Decades old internal strife has had major repercussions for the Cambodian economy. Agriculture remains its main economic sector, accounting for 43 per cent of its GDP (gross domestic product) and employing 55 per cent of the population as of 2004. In recent years, the GDP has grown considerably (from 8.4% in 2000 to 13.4% in 2005) but the economic expansion was primarily driven by the garment and tourism sectors. Per capita income remains considerably lower when compared with other countries in the region and is consistently one of the lowest in the world.

Cambodia follows the general pattern of internal migration in that movement is prevalent from rural to urban areas and from internal rural areas to border areas. Lack of employment opportunities, increasing landlessness and poverty in rural areas are

¹ from the Situation Report on International Migration in East and South-east Asia, Regional Thematic Working Group on International Migration including Human Trafficking, 2008.

driving this internal migration while the push factors are often linked to incentives prompting international migration.

Cambodia has only recently opened its doors to regular labour migration. The government is actively promoting labour migration policies and programmes to improve labour migration management. However, many workers continue to choose irregular channels, mainly because of the cost and time associated with regular migration and general distrust toward the bureaucratic procedures involved.

Most of the migration from Cambodia is to Thailand. As of 2005, there were 104,789 registered Cambodian labour migrants in Thailand, representing approximately 13 per cent of the total number of legal migrant workers in that country. While the majority of migrants to Thailand move voluntarily, trafficking from Cambodia to Thailand and to other countries is a problem.

Cambodia is a destination country for both labour and other types of migrants, some of who have settled permanently, primarily from Viet Nam and China. Vietnamese migrants are by far the biggest migrant group in Cambodia. It is difficult to estimate the exact numbers of both Chinese and, in particular, Vietnamese migrants in Cambodia due to historical relocations, including Kampuchea Krom residents and Vietnamese nationals who migrated to Cambodia between 1980 and 1989. However, Asian Migrant Centre (2002) estimated that there are more than one million Vietnamese migrants in Cambodia.

Despite efforts to strengthen the legal framework for combating trafficking of persons in general, trafficking of women and girls from Viet Nam as commercial sex workers to Cambodia still constitutes a serious problem and is the major pattern of this activity to the country. Trafficking from and within Cambodia is also a concern. In particular, women and children are trafficked internally and to neighbouring countries such as Thailand, China, Malaysia and Viet Nam to work as domestic workers, beggars, or in the sex industry. Cambodian men are more likely to be trafficked for work in the construction and fishing industries. Due to the clandestine nature of trafficking, accurate estimates of the number of victims involved are difficult to obtain. However, trafficking from Cambodia should be viewed in the wider context of labour-oriented irregular migration from the country in which a proportion of the migrants can be expected to fall victims to trafficking networks.

The Bavet-Mocbai cross-border point, which is close to the study sites, became an international border crossing in 2005. More than 850 people go through this cross-border point every day. On August 2008, Samrong-Samor—another cross-border point, was opened as an international border crossing area.

B. Pandemic Preparedness Situation in Cambodia²

Cambodia established a “National Working Group on Pandemic Planning” to develop inter-ministerial coordination mechanisms and multi-sector operational response plans for a pandemic emergency. The National Centre for Disaster Management was officially designated to serve as the coordinating body for multi-sectoral preparedness. A sub-national pilot project is under way in Siem Reap province to develop a multi-

² from Responses to AI and State of Pandemic Readiness, 4th Global Progress Report, UNSIC & The World Bank, Oct 2008.

sector operational pandemic response planning process. Key features of the process include:

- dynamic group participation
- acknowledgement of the necessity for self-reliance
- an emphasis on the need to plan around available resources.

This approach has created one of the first and few opportunities for disparate government departments to plan together. It is attracting active involvement from civil society groups and private businesses and the Cambodian Red Cross has become a key stakeholder in the process. Key outputs will include:

- a model provincial pandemic response plan, including standard operating procedures for each sector
- identification of policy gaps by operational, on-the-ground personnel to inform national-level planning
- a documented process to identify lessons learned, carried out by the University of Melbourne, to guide further extension of planning in Cambodia and other national or regional contexts.

As part of a commitment to strengthen border health quarantine services at key border provinces between Cambodia and Vietnam, the ministries of health of both countries signed the “Agreement between Cambodia and Vietnam on Border Health Quarantine Cooperation”.³ Efforts are now being made to use the agreement to help prevent disease transmission, reinforce existing cross border-health collaboration and increase preparedness in the event of any disease outbreaks. Emphasis will be made to ensure

³ Agreement between the Royal Government of Cambodia and the Socialist Republic of Vietnam on Border Health Quarantine signed in 06 March 2006.

close collaboration with the Cambodia and Vietnam border health agencies as core partners in the pandemic preparedness response.

C. Pandemic Preparedness for Migrants & Host Communities Project⁴

IOM is contributing to the global efforts of preparedness planning for avian and human influenza (AHI) and other pandemic threats through its participation in the UN System and Partners' Avian and Human Influenza (AHI) Consolidated Action Plan. Countries have responded to the threat of avian influenza at the national and community levels in varying degrees. However, cross-border areas and the people who live, work and move there have received only limited attention in pandemic preparedness strategies. Some national strategies have identified cross-border areas as germane to avian influenza transmission. However, the specific needs of migrants and cross-border communities as well as the pandemic preparedness capacity of border control and public health officers, particularly at the community/district level, warrant further attention.

In the first phase of the “Pandemic Preparedness for Migrants and Host Communities Project”, IOM implemented, through its missions in Viet Nam and Cambodia and in collaboration with UN Agencies, government partners and other stakeholders, activities that aimed to raise awareness and to strengthen pandemic preparedness in cross-border migrant communities. Pilot activities were carried out along the border districts in Svay Rieng, Cambodia and in Tay Ninh, Vietnam.

⁴ *from the Asia Component (Cambodia-Vietnam and Bangkok) of the Pandemic Preparedness for Migrants and Host Communities Project, Summary Project Document, International Migration Organization (IOM), 2008.*

The project's goal was to assist national, regional and global efforts for avian influenza response and pandemic preparedness by contributing to the UN System and Partner Consolidated Action Plan's objectives 6 and 7 (revised September 2007).

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

Specific Objectives of the project included the following:

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

D. Survey Objectives

This survey was one of the activities of this program. It aimed to do the following:

1. Provide the baseline information necessary to equip local authorities and key stakeholders, specifically the disaster management committee, and the tools for

putting together a more inclusive pandemic preparedness planning process at the community level.

2. Provide a profile of migrants in selected Svay Rieng areas and information on their mobility patterns, access to health and social services, knowledge and attitudes toward the concept of pandemic, level of preparedness or general feeling on ability to cope with a pandemic or any other crisis; and methods to strengthen migrant and host capacities for emergency preparedness at the community level.

E. Methodology

The study conducted 830 interviews of migrant-respondents during September-October, 2008 in two districts of Chantrea and Svay Teap in Svay Rieng province. This province was selected for various reasons.

Across the Greater Mekong Sub-region, there are joint border health programmes between Thailand and Cambodia, Cambodia and Lao PDR, Lao PDR and Thailand, Thailand and Myanmar and Cambodia and Vietnam. These programmes concentrate on communicable disease control with an emphasis on encouraging governments to adhere to the guidelines set by the International Health Regulations⁵ and the Asia-Pacific Strategy for Emerging Diseases⁶. The Cambodia and Vietnam cross-border health programme is not well-funded in comparison to the other programmes.

⁵ 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).

⁶ WHO, *Asia Pacific Strategy for Emerging Diseases*, Geneva, 2005 (available at www.wpro.who.int/NR/rdonlyres/FCEE9D-21BB-4A16-8530-756F99EFDB67/0/asia_pacific.pdf).

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, at the request of the health ministries of Cambodia and Vietnam supported the third cross-border health meeting between the two ministries.

In addition, IOM maintains a sub-office in Svay Rieng, which is carrying out a project on counter-trafficking. Through this project, IOM identified that there were a number of active cross-border migrant communities in Svay Rieng and Tay Ninh. IOM also implemented activities in the area, such as providing health screening for Cambodian returnees in partnership with the DSVY.

The table below shows the number of respondents according to migrant group and gender.

Table 2. Gender of Survey Respondents

Migrant Group	Female	Male	Total
Vietnamese migrants working in formal sectors	109	93	202
Vietnamese migrants working in informal sectors	160	43	203
Cambodian migrants working in formal sectors	119	99	218
Cambodian migrants returned from Vietnam	162	45	207
Total	550	280	830

The Vietnamese migrants working in formal sectors are employed at casinos and garment factories in Svay Rieng while the Vietnamese migrants working in informal sectors sell food, clothes and other products in shops or in markets along the border. Cambodian migrants working in formal sectors are from other provinces. They work in casinos, garment factories, etc. The Cambodian returnees are migrants who returned from Vietnam under the IOM counter-trafficking project in partnership with the DSVY.

A qualitative survey was also done along with this KAPB Survey. 10 FGDs were carried out between September 12 and 25, 2008, with 97 participants. FGD participants included VHSG, Cambodian returnees, garment factory workers, casino workers and Vietnamese migrant workers. The results are compiled in a separate report. Where relevant, the findings in the qualitative study will be correlated within the analysis of the findings in the KAPB survey.

Indochina Research, a research company with offices in Cambodia and Vietnam, carried out the data collection for the quantitative survey and conducted the FGDs. They also provided technical input during the development of the research tools, along with processing the data generated by the interviews.

F. Limitations

Because of the transient nature of migrants, it is difficult to ascertain the exact number of migrants that travel within Cambodia and those that cross the border to Vietnam on a regular basis. Thus, targeted sampling was used in the data collection.

Conceptually, pandemic preparedness among migrants is a relatively new term, not only to the migrants themselves but also to the key government partners and people who work with them. The IOM staff, the survey team along with the stakeholders and gatekeepers of this study had to familiarize themselves with the fundamentals of pandemic preparedness and how it applies on a practical level to everybody.

However, these limitations do not in any way affect the accuracy of the results. As a baseline survey, this study is certainly relevant not only to the programme planners and implementers within IOM, but also to other sectors that work with migrant populations in health and social services.

Findings and Analysis

G. Demographic Profile

Table 3. Socio-demographic Profile of Respondents

Demographic Characteristics	Total		Female		Male	
	n	%	n	%	N	%
<i>Nationality</i>						
Cambodian	425	51.0	281	51.0	144	51.0
Vietnamese	405	49.0	269	49.0	136	49.0
<i>Migrant Group</i>						
Vietnamese migrants working in formal sectors	202	24.0	109	20.0	93	33.0
Vietnamese migrants working in informal sectors	203	25.0	160	29.0	43	15.0
Cambodian migrants working in formal sectors	218	26.0	119	22.0	99	35.0
Cambodian migrants returned from Vietnam	207	25.0	162	30.0	45	16.0
<i>Age</i>						
<=20 Years	122	14.7	87	16.0	35	12.5
21-30 years	328	39.5	182	33.0	146	52.1
31-45 Years	250	30.1	178	32.0	72	25.7
>=45 Years	130	15.7	103	19.0	27	9.7
<i>Civil Status</i>						
Single/Never married	317	38.0	177	32.2	140	50.0
Married	464	56.0	328	59.6	136	48.6
Separated	10	1.0	8	1.5	2	0.7
Divorced	17	2.0	15	2.7	2	0.7
Widowed	22	3.0	22	4.0	-	-
<i>Educational Attainment</i>						
None	134	16.0	119	22.0	15	5.0
Some Primary	247	30.0	193	35.0	54	19.0
Completed Primary	117	14.0	75	14.0	42	15.0
Some Secondary	204	25.0	101	18.0	103	37.0
Completed Secondary	114	13.0	56	10.0	58	21.0
Technical / Vocational / University	14	2.0	6	1.0	8	3.0

Table 3 illustrates the demographic characteristics of the respondents. More than half of the respondents were female (66%) while females made up 53 per cent of the FGD participants. The number of Cambodian and Vietnamese respondents was almost equal because efforts were made by the research team to ensure a balanced representation from both nationalities.

In terms of age, 40 per cent of the respondents were between the ages of 21 and 30 years old. Females tended to be younger; 71 per cent of the respondents under the age of 20 years were female. Those between the ages of 31 and 45 years old followed closely at 30 per cent (74 per cent of whom were female). The percentage of respondents 21-45 years old equalled 70 per cent, similar to the 74 per cent figure for the FGD participants for the same age group.

In terms of civil status, 56 per cent of the respondents were married, of whom 70 per cent were female. However, of those who were single (30 per cent of the respondents), females and males were almost equally proportioned, at 55 per cent and 45 per cent, respectively.

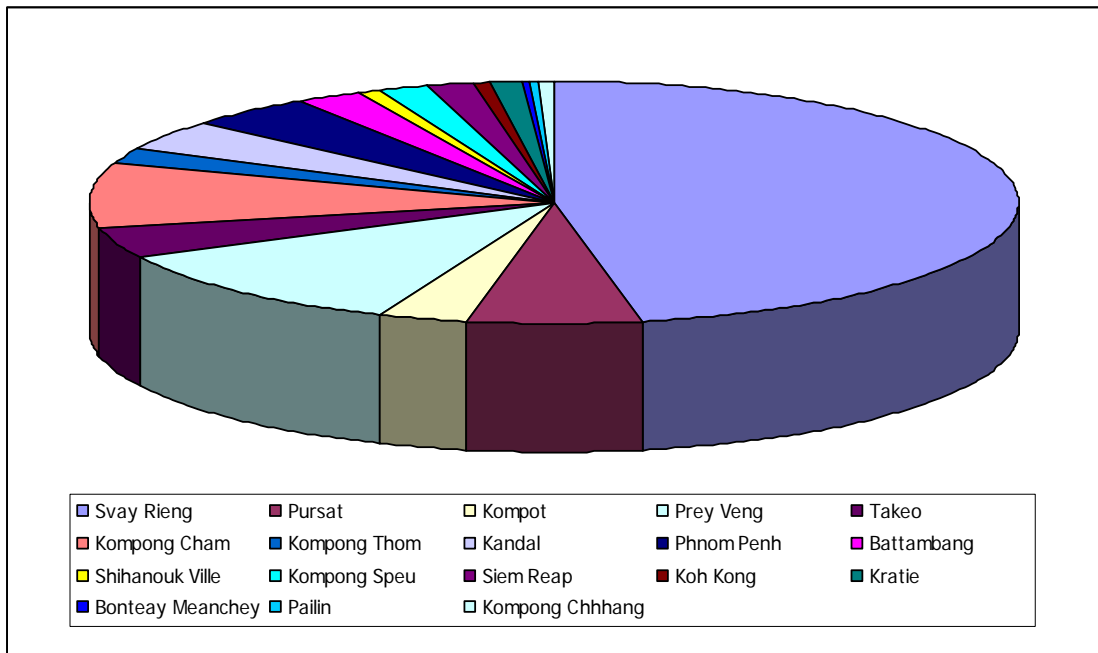
Regarding educational attainment, most of the respondents attended primary school (44%) and high school (38%). 14 per cent of the respondents completed primary school while 13 per cent completed secondary school. 16 per cent of the respondents did not receive any formal schooling at all; 88 per cent of whom were female.

Respondents working in the formal sectors (garment factories, casinos) tended to have less children than the other respondents. Cambodian migrants working in the formal sector had a 1.6 mean number of children and Vietnamese migrants working in the formal sector had a 1.5 mean number of children. Cambodian returnees and Vietnamese migrants working in informal sectors had 2.6 and 2.5 mean numbers of children, respectively.

16 per cent of the respondents spoke languages other than their native Khmer or Vietnamese. Of those, 71 per cent spoke English, followed by Chinese at 19 per cent, Thai (4%), French (3%), Korean (2%), and Bahasa Indonesia (1%). Respondents with these language skills were mostly employed at casinos, which are patronized by people of other nationalities.

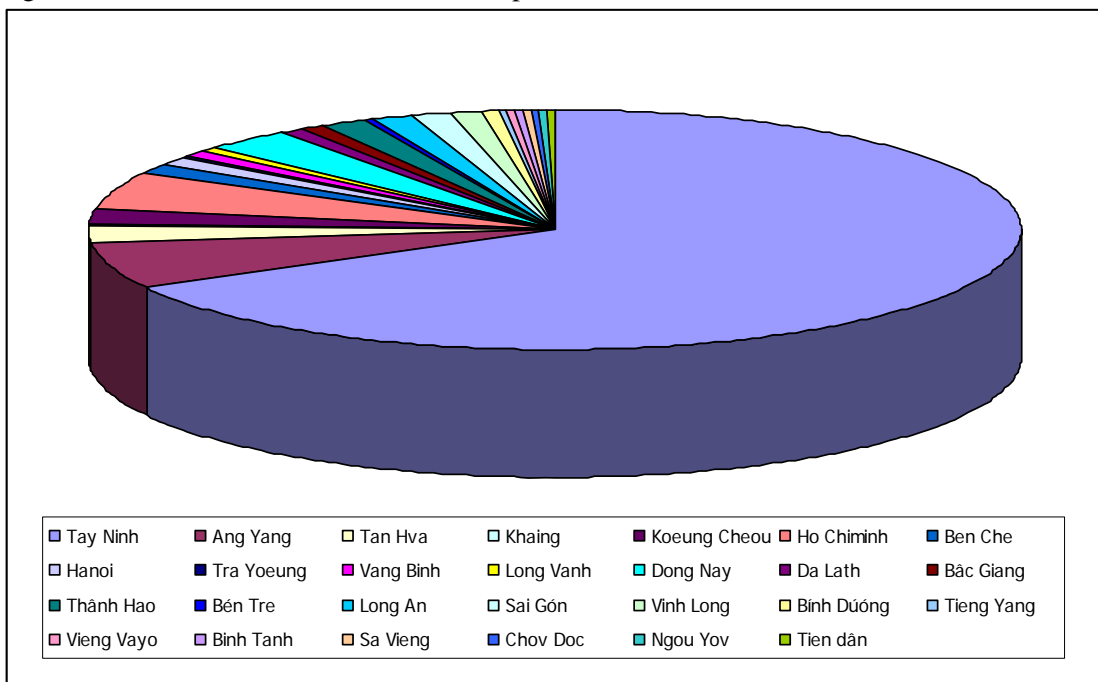
H. Migration Patterns

Figure 1. Birth Province of Cambodian Respondents



(N=425)

Figure 2. Birth Province of Vietnamese Respondents



(N=405)

Figures 1 and 2 summarize the birth province of the respondents. A majority of the respondents were born in the border provinces of Svay Rieng in Cambodia (47 %) and

Tay Ninh in Vietnam (67 %). The five highest birth places after Svay Rieng were Prey Veng (11%), Kampong Cham (9%), Pursat (6%), Phnom Penh (5%), and Takeo and Kandal (both 4%). After Tay Ninh, the five highest birth places were Ang Yang (6%), Ho Chi Minh City (5%), Dong Nay (3%), Tan Hva (2.2%), and Koeung Cheou (2%).

Table 4. Duration of Residency in Svay Rieng

Migrant Groups	Females	Males
Vietnamese migrants working in formal sectors	20	20
Vietnamese migrants working in informal sectors	60	32
Cambodian migrants working in formal sectors	24	21
Cambodian migrants returned from Vietnam	76	86

(mean number of months)

Table 4 shows, the mean number of months of the duration of the respondents' stay in the study sites. Male Vietnamese migrants working in the informal sector tended to be more mobile than Vietnamese females in the same sector, who have stayed longer in Svay Rieng. Most of the Cambodian returnees from Vietnam are long-term residents explaining the high figures for both females and males.

70 per cent of the respondents worked in the study areas throughout the year. Of this figure, 63 per cent were females. 10 per cent of the respondents identified themselves as seasonal workers, of whom 76 per cent were females. 90 per cent of the seasonal workers return to their home provinces when they are not working in the study sites. This movement is comparable to that of the FGD participants. The majority of them stated that they had been working as migrant workers for an average of 1-4 years. Cambodian migrants returned from Vietnam claimed they worked as migrants in a seasonal capacity, going to Vietnam for intermittent short periods of time (2 weeks to 2 months).

Table 5. Reasons for Leaving Home Province

Reasons	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	Female	Male	Female	Male	Female	Male	Male	Female
Search of better income	50	32	74	84	26	36	48	44
Search of better job	21	28	8	9	24	40	9	12
More jobs at destination	6	17	4	2	10	10	10	13
Lack of jobs at home	8	6	13	5	19	7	28	22
Went with friend/relative	13	4	1	-	18	7	3	9
Problems at home	-	-	-	-	3	-	1	-
Forced to go	2	13	-	-	-	-	1	-
Total (%)	100	100	100	100	100	100	100	100

(%)

Table 5 summarizes the migrants' reasons for migrating. Across all migrant groups, the most popular reason for migrating is economic in nature, seeking higher income or a better job. This reflects the finding of “Situation Report on International Migration in East and South-east Asia”, which stated that internal migration in Cambodia is driven by factors such as a lack of employment opportunities, increasing landlessness and poverty in rural areas.⁷

Table 6. Frequency of Home Visits

Frequency	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	Female	Male	Female	Male	Female	Male	Female	Male
Daily	10	8	81	67	6	3	88	84
2-4 times a month	13	15	6	12	0	1	11	13
Once a month	39	38	3	7	18	23	1	3
3 or 4 times a year	18	19	1	0	48	38	--	--
Twice a year	4	4	2	0	23	20	--	--
Once a year	10	8	6	12	3	8	--	--
< once a year	6	8	1	2	2	7	--	--
Total (%)	100	100	100	100	100	100	100	100

⁷ Situation Report on International Migration in East and South-east Asia, Regional Thematic Working Group on International Migration including Human Trafficking, 2008; p12.

Table 6 shows the frequency the migrant workers return to their home provinces. The respondents who were working in the formal sector such as garment factories and casinos tended to return to their home provinces once a month or 3-4 times a year, while those who worked in the informal sector went back home on a daily basis.

Table 7. Living Arrangements of Respondents

Co-habitants	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	Female	Male	Female	Male	Female	Male	Female	Male
Relative	47	23	71	58	56	36	70	76
Friend	24	29	7	16	23	18	10	16
Co-workers	22	39	2	5	17	44	2	4
People from same village	2	1	8	7	2	--	17	2
Alone	7	8	12	14	2	2	1	2

(%)

The preceding table shows the living arrangements of the respondents. Across all migrant groups, female respondents were more likely to live with their relatives. Meanwhile, migrant workers who lived alone were more likely to be Vietnamese.

I. Pandemic Preparedness

An average of 87 per cent of the respondents said that they have heard of infectious diseases that can spread among many communities. The level of awareness is relatively high among all groups, the highest being among the Cambodian migrants in the formal sector (96%) and the lowest among Vietnamese migrants also in the formal sector (82%).

When asked what these diseases might be, HIV/AIDS was identified by 75.6 per cent of the respondents, followed by avian influenza (66.4%), Dengue Fever (16.8%),

Malaria (10.7%), and Severe Acute Respiratory Syndrome (SARS) (8.8%). This is comparable to the findings in the FGDs, in which both avian influenza and HIV/AIDS were identified by all participants as contagious diseases that can be transmitted locally, nationally or even globally.

On average, 84 per cent of the respondents stated they were worried that they or their loved ones would be infected by diseases. This attitude is more common among the Cambodian respondents (90 per cent and 94 per cent among Cambodian migrants in the formal sector and Cambodian returnees, respectively) followed by the Vietnamese respondents (73 and 74 per cent among Vietnamese migrants in the formal sector and Vietnamese migrants in the informal sector, respectively). When asked to clarify what the diseases might be, 77.8 per cent identified HIV/AIDS, followed by avian influenza (59.5%), Dengue Fever (44.6%), Malaria (33.1%), and SARS (9.7%).

Meanwhile, 65 per cent of the respondents, across all migrant groups, who were not worried about contracting a disease, believed this was because they are able to “protect” themselves. 32 per cent said they were not exposed to any disease and 27 per cent said it was because they were healthy and strong.

Table 8. Frequency of Disease Outbreak in Respondent’s Community

Migrant Groups	Yes	No
Vietnamese migrants working in formal sectors	32	68
Vietnamese migrants working in informal sectors	30	70
Cambodian migrants working in formal sectors	66	34
Cambodian migrants returned from Vietnam	84	16

(%)

When asked if they have seen an outbreak of disease in their community, most of the Cambodian respondents responded positively while a majority of the Vietnamese gave the opposite response.

59 per cent of the respondents who have witnessed an outbreak of disease in their community said they first learned about it through their neighbours. This was followed by relatives (57%), friends (24%) and the media (21%). An additional 7 per cent stated that their awareness of the disease stemmed from being directly affected by the disease

Table 9. Initial Response in a Hypothetical Situation of an Outbreak of Disease

Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Get medical help	115	56.9	104	51.2	122	56.0	74	35.7
Store medicines (stockpiling)	89	44.1	111	54.7	121	55.5	164	79.2
Take preventive steps from catching the disease	113	55.9	97	47.8	98	45.0	111	53.6
Move away from your community	23	11.4	31	15.3	22	10.1	8	3.9
Nothing	3	1.5	3	1.5	2	0.9	--	--
Don't know	2	1.0	--	--	1	0.5	--	--
Report to village chief	2	1.0	--	--	7	3.2	4	1.9
Inform other people	1	0.5	--	--	1	0.5	5	2.4
Contact doctors	1	0.5	9	4.4	6	2.8	4	1.9

Table 9 lists the first things that the respondents would do if a disease outbreak occurred in their community. Among the Cambodian migrants working in the formal sectors, the most popular answers were getting medical help (56%) and stockpiling medicines (55.5%). Similarly, the Vietnamese migrants working in the formal sectors would first seek medical help (57%), followed by taking measures to avoid catching the disease (56%). The Vietnamese migrants working in the informal sector, meanwhile, said they would first stockpile medicines (55%) then seek medical help (51%). In the same fashion, a good majority of the Cambodian migrants returned from Vietnam said they would stockpile medicines first (79%), and then take preventive steps from catching the disease (54%).

The primacy of seeking medical help during a disease outbreak among the respondents who work in the formal sector (Cambodian migrants working in the formal sectors and Vietnamese migrants working in the formal sectors) indicates an awareness of or access to medical services and facilities, which is provided or at least facilitated by their employers. Migrants who were involved in informal sectors were more likely to be accustomed to doing things and solving problems on their own. This explains why the actions they would take tended to be self-initiated, instead of involving other people or service providers.

All FGD participants stated they would inform local authority (village and commune) and health staff if a disease outbreak occurred. Other key people or institutions they would wish to solicit assistance from included NGOs, animal health workers, neighbours, the commune agricultural department and the community network.

When asked what they thought should be done if someone they knew was infected, 70 per cent of the respondents said they would bring that person to the hospital, followed by 52 per cent who said they would take the person to the health centre. About 24 per cent said they would buy medicines from the pharmacy while 12 per cent said they would report to the village chief, and 7 per cent said they would report to the village animal health worker.

J. Emergency Preparedness

90 per cent of the respondents said it was good to prepare for an emergency. This opinion was most commonly shared by the Cambodian migrants returned from Vietnam (99%) and the Cambodian migrants working in the formal sectors (98%), to a

lesser degree, among Vietnamese migrants working in the formal sectors (82%) and Vietnamese migrants working in the informal sector (80%). When asked if they had made any preparations in case an outbreak or natural disaster occurred in their community, most of the Cambodian respondents (60%) and less than half of the Vietnamese respondents (46%) answered positively.

Table 10. Respondents' Preparation for an Emergency

Plans/ Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Store Food / Water	90	86.5	80	93.0	89	72.4	116	93.5
Money/ Emergency Fund	39	37.5	27	31.4	29	23.6	28	22.6
Leave town / Evacuation	32	30.8	31	36.0	16	13.0	12	9.7
How to get medical help	25	24.0	16	18.6	18	14.6	10	8.1
Where to get info	17	16.3	12	14.0	8	6.5	3	2.4
Who to contact	12	11.5	14	16.3	8	6.5	5	4.0
Where to go if homeless	10	9.6	6	7.0	15	12.2	6	4.8
Government / NGO Preparedness plan	7	6.7	10	11.6	8	6.5	3	2.4
How to contact them	14	13.5	3	3.5	7	5.7	2	1.6
Others	2	1.9	0	0.0	11	8.9	14	11.3

Table 10 outlines the preparations and response of the respondents (per migrant group) in the likelihood of an emergency. Across all migrant groups, the most common action was to store food and water (86%). Having money or an emergency fund was the second most common response (28%), followed by evacuation (21%), knowing how to get medical help (16%), and getting information (9%).

When asked how they would contact their loved ones in emergencies, 60 per cent of the respondents said they would do so by mobile telephone, followed by a public

landline telephone (33%), and sending a verbal message through another person (30%).

Table 11. Respondents' Initial Action in an Emergency

Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Stay home	30	14.9	32	15.8	40	18.3	50	24.2
Leave the town	103	51.0	105	51.7	116	53.2	90	43.5
Talk to others	96	47.5	52	25.6	92	42.2	99	47.8
Ask for help	101	50.0	119	58.6	85	39.0	81	39.1
Nothing	4	2.0	14	6.9	6	2.8	2	1.0
Don't Know	1	0.5	--	--	--	--	2	1.0
Others	7	4.0	5	3.0	37	17.0	64	30.0

Table 11 lists the respondents' first actions during an emergency. Across all migrant groups, leaving—or evacuation—was the most popular response (50%), followed closely by asking for help (46.5%) then by talking to other people (41%). About 18 per cent said they would stay at home. When there is flood or a cyclone, evacuation is probably the best action to take. However, in a pandemic event scenario where health and facilities are overwhelmed, staying at home is the best option.

Table 12. Government Authorities to Contact in an Emergency

Government Authority	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Health services	52	40.3	43	43.0	37	26.6	14	10.8
Emergency services	37	28.7	10	10.0	13	9.4	7	5.4
Local government	97	75.2	75	75.0	118	84.9	123	94.6
Police	21	16.3	18	18.0	31	22.3	9	6.9
Others	5	3.0	6	6.0	20	14.0	15	12.0

Other than the Vietnamese migrants working in the informal sector, the majority of the members in each group affirmed awareness of which government authority to contact

for help during a natural disaster or a disease outbreak with 83 per cent of all respondents, selecting local government. This was followed by health services (29%), police (16%) and emergency services (14%).

FGD participants identified government agencies such as the DSVY and non-governmental organizations such as the CRC, WFP, and Catholic Relief Services CRS as those who would respond and provide assistance to them.

Table 13. Government Assistance to Migrants in an Emergency

Ways of Helping	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Educate/ Prepare People	45	22.3	9	4.4	53	24.3	13	6.3
Provide early warning	43	21.3	18	8.9	47	21.6	28	13.5
Inform People	43	21.3	21	10.3	51	23.4	15	7.2
Have medicine ready	105	52.0	101	49.8	76	34.9	112	54.1
Have food ready	146	72.3	168	82.8	182	83.5	197	95.2
Have money fund ready	65	32.2	87	42.9	60	27.5	98	47.3
Have shelter ready	93	46.0	114	56.2	109	50.0	135	65.2
Have transport ready	21	10.4	34	16.7	34	15.6	28	13.5
Others	--	--	--	--	3	1.0	1	--

Table 13 illustrates the respondents' perspectives on the most appropriate ways the government can help during emergencies. Across all migrant groups, 84 per cent believed that having food ready to be the most important measure. This was followed by having access to shelter (54%), medicines (48%) and monetary assistance (37%) and by providing early warning (16.4%). Providing information, a key strategy in pandemic preparedness, was selected by only 15.7 per cent of the respondents.

K.

Access to Health Services and Health-Seeking Behaviour

Access to Health Information

Table 14. Access and Ownership of Media and Communication Equipment (%)

Migrant Group	Television		DVD Player		Radio		Landline Phone		Mobile Phone	
	Access	Owned	Access	Owned	Access	Owned	Access	Owned	Access	Owned
Vietnamese migrants working in formal sectors (N=202)	76	39	53	43	43	52	9	61	70	49
Vietnamese migrants working in informal sectors (N=203)	5	90	4	88	2	100	2	100	3	43
Cambodian migrants working in formal sectors (N=218)	92	48	49	76	57	80	6	50	84	79
Cambodian migrants returned from Vietnam (N=207)	60	80	28	95	40	84	--	--	11	57

Table 14 shows the access to and ownership of media equipment. The Cambodian respondents tended to have more access to a television, video player, radio and mobile phone compared to the Vietnamese respondents. The popularity of the television is reflected in the 2005 Cambodian Demographic and Health Survey (CDHS), which pegged the ownership of television in rural households at 52.3 per cent, compared to the radio (47.3%).⁸

Access to and ownership of landline phones is very rare across the migrant sectors and actually non-existent among the Cambodian migrants who returned from Vietnam.

⁸ Cambodia Demographic and Health Survey, Ministry of Planning, 2005; p22.

Landline phones are still not readily available, even for non-migrants, especially in a predominantly rural province like Svay Rieng. Throughout Cambodia, mobile phones are easier to access and own.

Table 15. Sources versus Trusted Sources of News

Source of News	%	Trusted Source of News	%
1. Television	94	1. Television	91
2. Radio	72	2. Radio	52
3. Newspapers	31	3. Newspapers	16
4. Neighbours	28	4. Family/Relatives	14
5. Family/Relatives	18	5. NGOs or Companies	13
6. Friends	15	6. Neighbours	10
7. NGOs or Companies	14	7. Village Chief	6
8. Co-workers	10	8. Co-workers	.04
9. Village Chief	10	9. Friends	.03
10. Loudspeaker	.03	10. Loudspeaker	.02
11. Commune Official	.02	11. Commune Official	.01

When asked about their sources of news and information, 94 per cent of the respondents said television was their primary source, with 91 per cent declaring it was their most trusted source. The forms of broadcast and print media – TV, radio, and newspapers – were the top three for sources as well as for trusted sources of information. Families and NGOs/companies as sources of information were ranked 5th and 7th, respectively but rose to 4th and 5th places as trusted sources of information.

The majority of FGD participants received news from television, radio, friends, the village chief and the commune chief. The Vietnamese migrants were inclined to rely more on TV and radio as their primary sources of information, whereas the Cambodian migrants tended to access information from a wide range of sources. Health education was identified as coming from organizations like Reproductive Health Association of Cambodia (RHAC) and IOM⁹, radio, magazines, IEC materials, television, company leaders, family, health staff and doctors.

⁹ IOM implemented a PRM-funded programme (October 2006 to December 2008) on Trafficking Prevention and Victim Protection with a health component providing training to trafficked and other vulnerable children on reproductive and sexual health as life skills.

Table 16. Sources versus Trusted Sources of Health Information

Source of Health Information	%	Source of Trusted Health Information	%
1. Television	91	1. Television	82
2. Radio	62	2. Radio	41
3. Doctors	38	3. Doctors	36
4. Newspapers	24	4. NGOs or Companies	16
5. NGOs or Companies	21	5. Newspapers	10
6. Neighbours	15	6. Neighbours	7
7. Family/ Relatives	11	7. Health Centre	6
8. Friends	9	8. Family/ Relatives	6
9. Health Centre	8	9. Village Chief	5
10. Pharmacy	7	10. Pharmacy	4
11. Village Chief	7	11. Friends	3
12. Co-worker	4	12. Co-worker	2
13. Billboard	4	13. Commune Official	1
14. Poster/ Pamphlet	3	14. Poster/ Pamphlet	1
15. Commune Official	2	15. Health Worker	1
16. Health Worker	1		

When asked about their sources of health information, the respondents ranked television, radio, and physicians as the top 3 sources. These were similarly ranked when it came to the most trusted sources of health information. Newspaper was the 4th most popular source of health information. However, its ranking dipped to 5th place as being a trusted source.

NGOs/companies, ranked the 5th most popular source of health information, became the 4th most trusted source of health information. Health centres, meanwhile, ranked as the 9th most popular source of health information, became the 7th most trusted source of health information.

The very low ranking for health worker, along with IEC materials such as posters and pamphlets could be attributed to the fact that health workers did not reach migrants while doing their field work which includes among its activities the distribution of

such materials to discuss health activities. The transient and mobile natures of migrants compound the problem. The inertia of the commune officials may stem from the fact that disseminating health information is not part of their duties and responsibilities.

Television was also the most-widely used form of media by the respondents with more than half of each population group (61-79%) stating they watch it daily. Except for the Vietnamese migrants who work in the formal sector, the rest of the respondents said they listen to the radio every day (37-47%) while most of the Vietnamese migrants working in the informal sector (72%) and the Cambodian returnees (95%) did not read newspapers at all.

An average of 72 per cent of the respondents said they did not receive any health education during the last twelve months. This rate was higher among the Vietnamese respondents (83 and 82 per cent among those working in the formal and informal sectors, respectively) and lowest among the Cambodian migrants returned from Vietnam (65%) and the Cambodian migrants working in the formal sectors (59%).

Health education provided to casino and garment factory workers depends largely on the existence of company initiatives. For migrants in the informal sector, it is delivered through outreach activities of local health authorities and NGOs. The figures indicate a low coverage of health education activities among migrants, regardless of work sectors.

Of those who received health education in the last year, the following topics were discussed with them:

Table 17. Health Education Topics

Topics	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Hygiene	19	54.3	12	32.4	26	29.2	29	39.7
Family Planning	8	22.9	4	10.8	2	2.2	6	8.2
Nutrition	8	22.9	1	2.7	8	9.0	9	12.3
Avian Influenza	10	28.6	11	29.7	15	16.9	49	67.1
HIV/AIDS	11	31.4	9	24.3	68	76.4	22	30.1
Dengue Fever	3	8.6	3	8.1	12	13.5	16	21.9
General Health	13	37.1	21	56.8	19	21.3	19	26.0
Others	0	0.0	0	0.0	19	21.0	2	3.0
Total	35	100.0	37	100.0	89	100.0	73	100.0

When health education was provided to the workers, the most common topic of discussion was hygiene. All four migrant population groups reported being taught mostly about hygiene and general health in discussions pertaining health education. The Cambodian migrants working in the formal sectors reported being informed about HIV/AIDS in the workplace, most probably because this topic is widely covered in Cambodia. As of 2006, at least four international and local NGOs worked with migrant workers in border areas on HIV prevention.¹⁰

The FGD participants had similar experiences in this area. They reported that they received health education on a range of topics such as disease prevention, hygiene and sanitation, and reproductive health. The Cambodian migrants returned from Vietnam provided the most extensive list of health education topics that they have been exposed to. The list including vaccinations, breast feeding, supplementary feeding of

¹⁰ <http://www.ilo.org/public/english/protection/trav/aids/publ/savingbook.pdf>; Saving Lives, Protecting Jobs—International HIV/AIDS Workplace Education Programme Interim Report; ILO; May 2006.

infants and children, dengue fever prevention, diphtheria, tuberculosis, goitres, respiratory problems, polio and avian influenza.

The survey found that 68 per cent of the respondents' health education sessions were carried out by NGOs or companies. This was followed by other health/medical staff (24%), commune officials (20%) and village health workers (17%). Among the FGD participants, health education was provided by organizations such as Reproductive Health Association of Cambodia (RHAC) and IOM, radio, magazines, IEC materials, television, company leaders, family, health staff and doctors.

Table 18. Barriers to Health Information

Barriers	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	#	%	#
Lack of access to media	75	37.1	39	19.2	79	36.2	104	50.2
Literacy	30	14.9	38	18.7	52	23.9	134	64.7
Language	81	40.1	62	30.5	112	51.4	153	73.9
Far from Health Provider	53	26.2	43	21.2	78	35.8	88	42.5
Lack of interest	67	33.2	122	60.1	76	34.9	84	40.6
Don't Know	2	1.0	--	--	1	0.5	--	--
None	12	5.9	4	2.0	19	8.7	1	0.5
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 18 outlines the barriers identified by the respondents in accessing health information. With the exception of the Vietnamese migrants working in the informal sector, the respondents chose language as the main barrier to getting health information. This may indicate that the Vietnamese and Cambodian respondents did not have access to health information—either in the form of materials or health teachings—in their native languages. Another explanation for this could be that the

health information and the materials available to them were written in “technical” terminology which is incomprehensible to them.

About a third of the respondents attended primary levels of schooling while 16 per cent did not have any formal schooling at all. An FGD participant identified the importance of using pictures as visual aids in health education.

It is worth noting that lack of interest seems to be an almost equally pervasive barrier to accessing health information. This was the 3rd or 4th most common barrier reported by the respondent groups with the exception of the Vietnamese migrants working in the informal sector, who ranked it as the most significant barrier. This lack of interest can be interpreted in various ways.

One explanation may be that the migrants are too busy working or seeking employment, to place a high priority on acquiring health information unless absolutely necessary, i.e. required by the company, or illness. It could also be due to a low perception of risk. If a person is healthy, he/she may not deem it necessary to take the time to learn about a specific disease.

Whatever the underlying reasons might be, addressing this barrier is as important and as critical as providing strategic solutions to other barriers such as the inaccessibility to media, language and literacy.

Table 19. Efficient Methods in Delivering Health Information

Methods	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
TV	161	79.6	155	76.3	118	54.1	96	46.4
Newspaper	3	1.5	6	3.0	2	0.9	--	--
Posters	1	0.5	--	--	4	1.8	2	1.0
Interpersonal communication	4	2.0	3	1.5	23	10.6	8	3.9
Announcements using loudspeakers in the villages	1	0.5	2	1.0	2	0.9	1	0.5
Announcements from the local authority	1	0.5	3	1.5	7	3.2	21	10.1
Radio	25	12.4	30	14.7	42	19.3	42	20.3
Magazine	1	0.5	--	--	2	0.9	--	--
Announcements from NGOs	3	1.5	4	2.0	11	5.1	30	14.4
Leaflets	1	0.5	--	--	3	1.4	6	2.9
Internet	1	0.5	--	--	--	--	1	0.5
Don't know	--	--	--	--	4	1.8	--	--
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 19 summarizes the respondents' opinions on resourceful ways to deliver health information to them. Television and radio were the most popular answers from all the migrant groups. Television was the most-widely used form of media by the respondents, with more than half of each population group (61-79%) watching it daily.

Vietnamese migrants who worked in the formal sector tended to listen to the radio every day. Respondents in the other migrant groups listened to the radio less frequently. 37-47 per cent was the range of respondents who said they listened to the radio at least once a week.

Personal networks were also important to the respondents. Depending on the migrant group, interpersonal communication was either the 3rd or 4th highest ranked means of delivering health information. Interpersonal communication, in the context of information delivery and dissemination, can consist of many forms. It can be as informal as invitations to community discussions or as strategic as peer education and counselling sessions.

The role of NGOs in health service provision, which almost always includes information dissemination, has been highlighted as well. As migrant workers have almost none or very limited access to social and health services, it is no surprise that NGO initiatives have somehow reached even a small percentage of migrant workers in the border areas.

Health Maintenance

Table 20. Healthy Lifestyle Habits

Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Balanced diet	69	34.2	44	21.7	38	17.4	33	15.9
Regular exercise	160	79.2	132	65.0	133	61.0	25	12.1
Proper hygiene	152	75.2	163	80.3	177	81.2	183	88.4
Regular medical check-up	23	11.4	13	6.4	58	26.6	77	37.2
Exposure avoidance	7	3.5	13	6.4	30	13.8	57	27.5
Health education	1	0.5	2	1.0	6	2.8	7	3.4
Get enough sleep	--	--	1	0.5	7	3.2	--	--
Eat enough food	1	0.5	--	--	1	0.5	2	1.0
Nothing	--	--	1	0.5	1	0.5	2	1.0
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 20 lists the actions the respondents claimed they undertook to remain healthy. A high proportion of them – across all migrant groups – thought that proper hygiene was the key to a healthy body. This was followed by exercise, which was chosen by all respondents, apart from the Cambodian migrants returned from Vietnam.

Similarly, the FGD participants said they remained healthy by (in order of frequency mentioned) getting enough sleep, eating clean and nutritious food, maintaining hygiene, exercising, keeping the house and surroundings clean, relaxing, wearing masks when working (factory workers), drinking boiled water, not drinking alcohol, getting regular medical check-ups and destroying mosquito breeding sites.

Table 21. Hand Washing Practices

Frequency	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Before eating	191	94.6	176	86.7	210	96.3	203	98.1
After eating	121	59.9	108	53.2	97	44.5	99	47.8
After using the toilet	116	57.4	115	56.7	109	50.0	57	27.5
Before preparing food	29	14.4	5	2.5	35	16.1	29	14.0
When they get dirty	108	53.5	123	60.6	128	58.7	141	68.1
While bathing	21	10.4	18	8.9	15	6.9	14	6.8
After working	82	40.6	70	34.5	69	31.7	72	34.8
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 21 details the hand washing practices of the respondents. Across all migrant groups, 94 per cent of the respondents said that they washed their hands before eating. This was followed by washing hands when they got dirty (60%), after eating (51%), after going to the toilet (47%), and after working (35%).

Table 22. Use of Soap in Hand Washing

Migrant Group		Always with soap	Sometimes with soap	Never with soap	Total
Vietnamese migrants working in the formal sectors	n	188	10	4	202
	%	93.1	4.9	2.0	100.0
Vietnamese migrants working in the informal sectors	n	182	13	8	203
	%	89.7	6.4	3.9	100.0
Cambodian migrants working in the formal sectors	n	113	104	1	218
	%	51.8	47.7	0.5	100.0
Cambodian migrants returned from Vietnam	n	37	168	2	207
	%	17.9	81.1	1.0	100.0

Table 22 outlines the respondents' use of soap when washing their hands. Excluding the Cambodian migrants returned from Vietnam, a high number of respondents said they always used soap when washing their hands, with figures ranging from 52 per cent (Cambodian migrants working in the formal sectors) to 93 per cent (Vietnamese migrants working in the formal sectors). A 2008 study commissioned by UNICEF found that washing one's hands with soap was reported by 83.3 per cent of its respondents.¹¹ About 81 per cent of the Cambodian migrants returned from Vietnam said they used soap sometimes. This compares with a rate of 48 per cent among the Cambodian migrants working in the formal sectors to a 5 and 6.4 per cent rate, for Vietnamese migrants working in the formal and informal sectors, respectively. In the UNICEF study, around 17 per cent reported that they sometimes or never washed their hands with soap.¹²

¹¹ Formative Research on Promoting Health and Social Change in Cambodia through Communication Programming, UNICEF, 2008; p44.

¹²Ibid

Table 23. Access to Water for Hand Washing

Migrant Group		Yes	No	Total
Vietnamese migrants working in the formal sectors	n	201	1	202
	%	99.5	0.5	100.0
Vietnamese migrants working in the informal sectors	n	201	2	203
	%	99.0	1.0	100.0
Cambodian migrants working in the formal sectors	n	216	2	218
	%	99.1	0.9	100.0
Cambodian migrants returned from Vietnam	n	203	4	207
	%	98.1	1.9	100.0
Total	n	821	9	830
	%	98.9	1.1	100.0

Across all migrant groups, 99 per cent of them reported having access to water for washing their hands. Apart from the Cambodian migrants returned from Vietnam, the migrant groups mostly got their water from the tap, with figures ranging from 55 per cent (Vietnamese migrants working in the informal sector) to 80 per cent (Vietnamese migrants working in the formal sectors). About 89 per cent of the Cambodian migrants returned from Vietnam said their water came from wells. In the UNICEF study, 93 per cent of the respondents said water for washing their hands was readily available to them.¹³

¹³ Ibid, p45.

Table 24. Actions Undertaken to Avoid Catching a Cough or Cold from other People

Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Avoid touching them	56	27.7	39	19.2	62	28.4	28	13.5
Avoid close contact with them	101	50.0	124	61.1	108	49.5	127	61.4
Move/Turn away from them when they cough or sneeze	52	25.7	84	41.4	90	41.3	123	59.4
Wash hands after contact with them	137	67.8	104	51.2	189	86.7	179	86.5
Send them for medical treatment	4	2.0	5	2.5	13	6.0	5	2.4
Nothing	53	26.2	42	20.7	37	17.0	39	18.8
Do not eat with other people	1	0.5	4	2.0	1	0.5	--	--
Sleep far from other people	--	--	--	--	2	0.9	1	0.5
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 24 lists the things that the respondents said they would do to avoid catching airborne diseases like a cough or cold from people who were close to them. The two most common means of avoiding infection from others were washing one's hands after becoming in contact with an infected person (ranked number one by respondents, except Vietnamese migrants working in the informal sector), and avoiding close contact with the infected person (ranked number two by respondents except by Vietnamese migrants working in the informal sector). Of note, a somewhat high proportion of the respondents said they would do nothing to avoid infection. This was more common among the Vietnamese migrants. However, among the four migrant groups, this emerged either as the 4th (Vietnamese migrants working in the formal and informal sectors, and Cambodian migrants returned from Vietnam) or 5th (Cambodian migrants working in the formal sectors) most popular response.

Table 25. Preventing the Infection of Cough or Cold to Others

Actions	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Wear a face mask	97	48.0	96	47.3	178	81.7	143	69.1
Avoid close contact with others	106	52.5	100	49.3	108	49.5	96	46.4
Cover my mouth when I cough/ sneeze	71	35.1	68	33.5	86	39.4	114	55.1
Avoid coughing/ sneeze on others	41	20.3	86	42.4	69	31.7	104	50.2
Get medicine from pharmacy	67	33.2	99	48.8	52	23.9	39	18.8
Blow nose and dispose of mucus	36	17.8	25	12.3	53	24.3	66	31.9
Get treatment from health centre	36	17.8	32	15.8	40	18.3	58	28.0
Avoid touching others	43	21.3	19	9.4	45	20.6	25	12.1
Wash hands	3	1.5	2	1.0	10	4.6	15	7.2
Rest at home	7	3.5	5	2.5	1	0.5	4	1.9
Do not eat with other people	-	-	3	1.5	2	0.9	4	1.9
Nothing	-	-	-	-	1	0.5	-	-
Sleep far from other people	-	-	-	-	-	-	1	0.5
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 25 shows the actions the respondents would take to avoid infecting others if they had a cough or cold. Among the Vietnamese respondents, the most common answer was avoiding close contact with others (52.5 and 49.3 per cent for Vietnamese migrants working in the formal sectors and Vietnamese migrants working in the informal sector, respectively). Among the Cambodian respondents, the majority chose wearing a face mask (81.7 and 69.1 per cent for Cambodian migrants working in the formal sectors and Cambodian migrants returned from Vietnam, respectively). The efficacy of using face masks is debatable. The masks filter out dust particles and possibly, even droplets, but do not provide protection against microscopic substances, such as bacteria and viruses.

The four most common actions (wearing a face mask, avoiding close contact with others, covering the mouth when sneezing/coughing and avoiding coughing/sneezing on others) mentioned by the respondents indicate that there is a relatively high awareness of how to prevent the transmission of diseases that are transmitted through droplet infection like coughs and colds.

It is interesting to note the relatively high figure for buying medicines from a pharmacy compared to getting treatment from a health centre. Across all migrant groups, buying medicines from a pharmacy was selected by 31 per cent of the respondents, well above the 20 per cent result for getting treatment at a health centre. Self-medication is prevalent in Cambodia for a multitude of reasons including patients' lack of access to physicians, lack of money and low level of trust in public health facilities.

Many people are still unaware of the negative health implications stemming from the misuse of drugs, especially antibiotics. However, in communities where access to physicians is limited—or in the case of migrants who are mostly transient, pharmacists are the closest substitute for medical consultation and treatment.

Health-Seeking Behaviour

When asked who they would turn to when they had problems, a majority of the Cambodian migrants working in the formal sectors (80%) and Vietnamese migrants working in the formal sectors (72%) said they would go to their parents while most of the Cambodian migrants returned from Vietnam (73%) and Vietnamese migrants working in the informal sector (52%) said they would seek help from their spouses/partners.

Age may be a contributing factor to this trend. Cambodian and Vietnamese migrants working in the formal sectors tended to be younger and still single compared to the Cambodian migrants returned from Vietnam and Vietnamese migrants working in the informal sector. Families (parents, spouses/ partners, and relatives) were the usual sources of support for the migrants.

Table 26. People or Places to Frequent when Ill

People/ Places	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Government hospital	127	62.9	135	66.5	109	50.0	101	48.8
Government health centre	44	21.8	47	23.2	52	23.9	173	83.6
Private doctor	60	29.7	47	23.2	125	57.3	57	27.5
Private hospital/ clinic	31	15.3	20	9.9	48	22.0	16	7.7
Health worker	8	4.0	11	5.4	3	1.4	3	1.4
Pharmacy	34	16.8	65	32.0	38	17.4	34	16.4
Coining	3	1.5	8	3.9	2	0.9	1	0.5
Other traditional healing methods	1	0.5	1	0.5	4	1.8	8	3.9
Relative	19	9.4	21	10.3	9	4.1	4	1.9
Company doctor	8	4.0	1	0.5	8	3.7	--	--
NGO doctors	--	--	2	1.0	1	0.5	1	0.5
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 26 enumerates the people or facilities respondents seek help from when they feel sick. Across all migrant groups, the government hospital was the most popular place, with an average of 65 per cent. This was ranked highest among Vietnamese migrants working in the formal sectors (63%) and Vietnamese migrants working in the informal sector (67%). Government health centre was ranked highest among Cambodian migrants returned from Vietnam, at 84 per cent. This is in contrast with the 2005 CDHS, which found that private sector facilities were utilized more than ones in the public sector in both rural and urban areas.¹⁴ Overall, the health centre had the 2nd highest ranking, with an average of 38 per cent.

¹⁴ In rural areas, the private sector was sought by 46.7% of those who were sick while 22% turned to the public sector; Cambodia Demographic and Health Survey; Ministry of Planning; 2005; pp34-35.

Cambodian migrants working in the formal sectors selected private doctors as their first choice (57%). Among Vietnamese migrants working in the formal sectors, private doctor was the 2nd most popular choice at 30 per cent. Compared with the other respondent groups, casino and garment factory workers have better access to private physicians and private clinics through their employers. Also, having a regular salary makes them more likely to be able to pay for medical services, and thus be able to consult private physicians.

As in the findings shown in Table 23, the pharmacy had a relatively high percentage among the respondents, with an average of 21 per cent, making it the 4th highest ranking after government hospital (65%), government health centre (38%), and private physician (34%). The Vietnamese migrants working in the informal sector ranked it number two, at 32 per cent.

Based on the FGD, Cambodians tended to seek health care at the local health centres only when they were seriously ill. Perhaps, cultural issues are underlying reasons for the preference towards seeking traditional remedies and faith-based support.¹⁵

Table 27. Reasons for Choosing Service Providers

Reasons	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Cost	37	18.3	77	37.9	81	37.2	129	62.3
Location	42	20.8	35	17.2	119	54.6	117	56.5
Trusted	157	77.7	130	64.0	146	67.0	113	54.6
Recommended	16	7.9	39	19.2	20	9.2	34	16.4
Ease or Convenience	72	35.6	62	30.5	102	46.8	115	55.6
Only known person/ place	7	3.5	1	0.5	8	3.7	18	8.7
Total	202	100.0	203	100.0	218	100.0	207	100.0

¹⁵ Report on Focus Group Discussion Qualitative Data Collection, Pandemic Preparedness for Migrants and Host Communities Project; IOM Cambodia; December 2008.

Trust was the main factor for the respondents to select the aforementioned people/facility in times of illness. However, among all the groups, Cambodian migrants returned from Vietnam chose the more practical reasons of cost and location. One of the reasons for the prevalence of self-medication in Cambodia is the distrust of public health facilities. Despite changes/improvements in the health care delivery system/standards, many people still feel it is better to go directly to a drug store and ask the pharmacist for medication to treat their symptoms. Nurturing their sense of trust in public health facilities through delivery of consistently high quality, accessible and affordable services is therefore critical.

Table 28. Frequency of Seeking Health Care Within the Past 12 Months

Frequency	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
None	52	25.7	98	48.3	45	20.6	48	23.2
One time	64	31.7	73	35.9	92	42.2	48	23.2
2-3 times	77	38.1	28	13.8	64	29.4	85	41.1
4-9 times	5	2.5	4	2.0	14	6.4	17	8.2
More than 10 times	4	2.0	--	--	3	1.4	9	4.3
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 28 shows how frequently the respondents sought health care during the past 12 months. Respondents working in the formal sector (Cambodian migrants working in the formal sectors and Vietnamese migrants working in the formal sectors) were more likely to have sought health care compared to those in the informal sector. A majority of them (72 and 70 per cent among Cambodian migrants working in the formal sectors and Vietnamese migrants working in the formal sectors, respectively) sought health care 1-3 times during the past year. This is primarily because they have better

access to health care at their workplace. In addition, their steady income makes accessing health care easier.

About half (48%) of the Vietnamese migrants working in the informal sector did not seek any health care last year. This is much higher than the 23 per cent of the Cambodian migrants returned from Vietnam who did not seek any health care within same period. Most of the Cambodian migrants returned from Vietnam (41%), in fact, sought health care 2-3 times last year. Access remains the major factor as the Cambodian migrants returned from Vietnam may not be receiving any assistance from their employers. Nevertheless, their awareness of health service providers and facilities in their communities enable them to seek health care when required.

Table 29. Service Providers and Facilities that Treated Respondents in the last 12 months

People/ Places	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Government hospital	96	47.5	67	33.0	58	26.6	63	30.4
Government health centre	30	14.9	25	12.3	37	17.0	116	56.0
Private doctor	42	20.8	33	16.3	65	29.8	31	15.0
Private hospital/ clinic	32	15.8	31	15.3	48	22.0	19	9.2
Health worker	3	1.5	6	3.0	13	6.0	11	5.3
Pharmacy	60	29.7	105	51.7	87	39.9	72	34.8
Coining	1	0.5	-	-	-	-	-	-
Other traditional healing	1	0.5	5	2.5	1	0.5	3	1.4
Relative	37	18.3	40	19.7	34	15.6	25	12.1
Company doctor	-	-	-	-	3	1.4	-	-
NGO doctors	2	1.0	1	0.5	7	3.2	1	0.5
Total	202	100.0	203	100.0	218	100.0	207	100.0

Table 29 lists the people and places the respondents sought treatment from in the last 12 months. There is a startling difference between the results here and those listed in

Table 24. When asked where they would go if they felt sick, the five most popular answers of the respondents were (1) government hospital, (2) government health centre, (3) private doctor, (4) pharmacy and (5) private hospital.

Further probing regarding the actual places where treatment was sought over the last 12 months, culminated in the following five most popular responses: (1) pharmacy, (39%), (2) government hospital, (34%), (3) government health centre, (25%) (4) private doctor, (21%) (5) relatives, (16%). Cambodian migrants working in the formal sectors (40%) and Vietnamese migrants working in the informal sector (52%) ranked the pharmacy first while the Cambodian migrants returned from Vietnam (35%) and Vietnamese migrants working in the formal sectors (30%) ranked it second. This clearly confirms the high frequency of self-medication usage among the respondents, regardless of migrant groups. The high ranking of relatives illustrates this point further, because self-medication also includes asking relatives what medicines to take when one is ill.

A similar pattern was found among the FGD participants. Purchasing medicines was identified by all participant groups as the action to take when they were sick. The pharmacy was also identified by 3 out of 4 participant groups as the place where they went to when they were sick.

Table 30. Barriers to Accessing Health Services

Barriers	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Getting permission to go	73	36	57	28	129	59	12	6
Getting money needed for treatment	98	49	141	70	155	71	192	93
Distance to the health facility	91	45	93	46	137	63	127	61
Having to take transport	79	39	89	44	137	63	130	63
Not wanting to go alone	89	44	65	32	135	62	118	57
Fear of lost of income	96	48	145	71	140	64	180	87
May not be able to communicate with health staff	71	35	91	45	131	60	119	58
May not be treated with respect	87	43	83	41	129	59	120	58
There may not be medicine available	81	40	61	30	131	60	125	60
Time that the service is available	102	51	102	50	153	70	123	59

Table 30 summarizes the barriers identified by the respondents to accessing health services. Economics effect the migrants' access to health services. Getting money for treatment was the most popular barrier among the Cambodian respondents (71 and 93 per cent among Cambodian migrants working in the formal sectors and Cambodian migrants returned from Vietnam, respectively) and the second most popular barrier among the Vietnamese respondents (49 and 70 per cent among Vietnamese migrants working in the formal sectors and Vietnamese migrants working in the informal sector, respectively). Another economic factor—fear of loss of income, was also popular among all migrant groups. It was highest among Vietnamese migrants working in the informal sector (71%), second highest among Cambodian migrants returned from Vietnam (87%) and third highest among Cambodian migrants working

in the formal sectors (64%) and Vietnamese migrants working in the formal sectors (48%).

The opening hours of the service facilities proved to be a significant barrier among Cambodian migrants working in the formal sectors (51%) and Vietnamese migrants working in the formal sectors (70%). Most casino and garment factory workers do not work regular hours at 9 to 5 jobs, but usually work 8-hour shifts at odd hours, with weekly or monthly rotations. More often than not, their free time does not coincide with the schedule of many public and private sector health facilities. This can also be one of the reasons why pharmacies are very popular as they are usually open for most of the day.

Difficulties identified by FGD participants when accessing health care services included (1) the distance to the health service facility/provider, (2) lack of attention from doctors, (3) lack of money to pay for services, (4) unavailability of medicines at the health centres and (5) absence of a health centre in the village.

Avian Influenza

On a conceptual level, there is a close relationship between pandemic preparedness and avian influenza. A pandemic means any disease that can affect many regions or countries simultaneously, such as HIV infection, Tuberculosis, and Malaria. But among laymen, pandemic preparedness is almost always associated with avian influenza.

Table 31. Awareness of Avian Influenza

Migrant Group		Yes	No	Total
Vietnamese migrants working in the formal sectors	n	198	4	202
	%	98.0	2.0	100.0
Vietnamese migrants working in the informal sectors	n	195	8	203
	%	96.1	3.9	100.0
Cambodian migrants working in the formal sectors	n	218	0	218
	%	100.0	0.0	100.0
Cambodian migrants returned from Vietnam	n	202	5	207
	%	97.6	2.4	100.0
Total	n	813	17	830
	%	98.0	2.0	100.0

Table 31 shows the very high level of awareness of avian influenza among all migrant group respondents. Only 2 per cent of all the respondents admitted to not having heard of avian influenza.

Table 32. Source of Knowledge Regarding Avian Influenza

Source of Information	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Newspaper	104	52.5	28	14.4	36	16.5	1	0.5
Radio	106	53.5	117	60.0	178	81.7	179	88.6
Television	186	93.9	186	95.4	212	97.2	182	90.1
Loudspeaker	15	7.6	6	3.1	3	1.4	16	7.9
Family/ relatives	12	6.1	17	8.7	16	7.3	18	8.9
Friends	25	12.6	3	1.5	42	19.3	6	3.0
Neighbours	41	20.7	44	22.6	35	16.1	87	43.1
Co-workers	14	7.1	1	0.5	32	14.7	-	-
Organization	9	4.5	3	1.5	37	17.0	71	35.1
Village chief	4	2.0	4	2.1	22	10.1	51	25.2
Commune official	8	4.0	6	3.1	11	5.0	3	1.5
Doctor	-	-	1	0.5	-	-	3	1.5
Poster/ leaflet	-	-	-	-	5	2.3	3	1.5
At health centre	-	-	-	-	4	1.8	1	0.5
Along the road	-	-	-	-	3	1.4	1	0.5
Through Internet	-	-	-	-	1	0.5	-	-
Total	198	100.0	195	100.0	218	100.0	202	100.0

Table 32 indicates the respondents' sources of knowledge of avian influenza. Across all migrant groups, the two highest-ranked sources of information were the television

(94.2%) and radio (71.3%). Neighbours ranked third, with an average of 26 per cent, about five percentage points higher than newspapers.

Table 33. The Potential of Bird Flu Being Transmitted to Humans

Migrant Group		Yes	No	Don't know	Total
Vietnamese migrants working in the formal sectors	n	192	6	4	202
	%	95.0	3.0	2.0	100.0
Vietnamese migrants working in the informal sectors	n	187	7	9	203
	%	92.1	3.4	4.4	100.0
Cambodian migrants working in the formal sectors	n	217	1	0	218
	%	99.5	0.5	0.0	100.0
Cambodian migrants returned from Vietnam	n	201	0	6	207
	%	97.1	0.0	2.9	100.0
Total	n	797	14	19	830
	%	96.0	1.7	2.3	100.0

The findings in Table 31 reveal that an overwhelming majority of the respondents understood that humans can catch flu from birds. Awareness was highest among Cambodian migrants working in the formal sectors (99.5%) and lowest among Vietnamese migrants working in the informal sector (92.1%).

Table 34. Transmission of Flu from Poultry to Humans

Mode of Transmission	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	%
Contact with infected poultry	153	78.1	135	68.9	173	79.7	176	85.0
Contact with infected poultry faeces	62	31.6	46	23.5	79	36.4	73	35.3
Eating undercooked infected poultry/ eggs	143	73.0	150	76.5	167	77.0	164	79.2
Eating raw poultry products (i.e. blood pudding)	58	29.6	72	36.7	72	33.2	39	18.8
Slaughtering poultry	16	8.2	6	3.1	10	4.6	4	1.9
Don't know	4	2.0	12	6.1	1	0.5	6	2.9
Total	196	100.0	196	100.0	217	100.0	207	100.0

Table 34 illustrates that despite very high levels of awareness regarding avian influenza, the accuracy of such knowledge still leaves much to be desired. The majority of the respondents acknowledged that contact with infected poultry can transmit avian influenza to humans. Regular contact with infected poultry puts one at risk from avian influenza, but contact *per se* does not lead to avian influenza infection.

It is difficult to assess the respondents' understanding of the risk of becoming infected with avian influenza based solely on the answers to this question. However, it is obvious that across all migrant groups, there are misconceptions on how avian influenza is transmitted from poultry to humans.

A UNICEF study reported with similar findings. The study found that the respondents were more knowledgeable about the relation between sick poultry and traditional diseases such as cholera than the causes of avian influenza. According to the aforementioned study, "there is a high level of not understanding the risks of avian influenza."¹⁶

Table 35. Awareness of Protection from Avian Influenza

Migrant Group		Yes	No	Total
Vietnamese migrants working in the formal sectors	n	166	36	202
	%	82.2	17.8	100.0
Vietnamese migrants working in the informal sectors	n	153	50	203
	%	75.4	24.6	100.0
Cambodian migrants working in the formal sectors	n	207	11	218
	%	95.0	5.0	100.0
Cambodian migrants returned from Vietnam	n	181	26	207
	%	87.4	12.6	100.0
Total	n	707	123	830
	%	85.2	14.8	100.0

¹⁶ Formative Research on Promoting Health and Social Change in Cambodia through Communication Programming, UNICEF, 2008; p204.

Similar to the findings displayed in Tables 31 and 33, a good majority of the respondents believed they knew how to protect themselves from avian influenza. This was highest among Cambodian migrants from the formal sectors (95%), and lowest among Vietnamese migrants from the informal sector (75%).

Table 36. Protection from Avian Influenza Techniques

Action	Vietnamese migrants working in formal sectors		Vietnamese migrants working in informal sectors		Cambodian migrants working in formal sectors		Cambodian migrants returned from Vietnam	
	#	%	#	%	#	%	#	
Do not eat undercooked poultry and eggs	122	73.5	108	70.6	136	65.7	116	64.1
Do not eat birds that fall dead	97	58.4	119	77.8	103	49.8	129	71.3
Wash hands with soap before and after handling food	67	40.4	37	24.2	109	52.7	77	42.5
Wear mask when handling poultry	36	21.7	33	21.6	104	50.2	97	53.6
Wash hands after handling poultry and poultry products	61	36.7	28	18.3	94	45.4	84	46.4
Don't eat chicken or duck blood pudding	42	25.3	49	32.0	36	17.4	36	19.9
Wear gloves when handling poultry	28	16.9	28	18.3	52	25.1	49	27.1
Change and wash clothes after handling poultry	14	8.4	7	4.6	25	12.1	35	19.3
Don't let children handle or play with poultry	17	10.2	12	7.8	28	13.5	18	9.9
Wear clothing when handling poultry	11	6.6	1	0.7	10	4.8	5	2.8
Others	5	3.0	3	2.0	13	6.0	4	2.0
Total	166	100.0	153	100.0	207	100.0	181	100.0

Table 36 summarizes the respondents' perception on how they should protect themselves from avian influenza. The two most popular answers were related to consumption of poultry and poultry products, followed by washing hands before and after handling food. Some of the recommended behaviours in preventing avian influenza, such as washing one's hands with soap after handling poultry, wearing

masks and gloves when handling poultry, and not letting children play with poultry were among the least popular answers. This indicates a gap of knowledge related to the findings in Table 32.

II. Conclusions and Recommendations

A. The following **conclusions** have been made according to thematic areas:

Demography

About two-thirds of the respondents were female and those tended to be younger, with 40 per cent of them within the 21-30 age group and 70 per cent of all respondents who were younger than 20 years were female. More than half (56%) of the respondents were married, with 70 per cent of them being female, while of the 30 per cent who were single, the proportion of females to males was only 55 to 45 per cent. Migrants of the formal sectors (garment factories and casinos) tended to have fewer children than the other respondents. 30 per cent of the respondents reached (at least started) primary school while another 25 per cent reached the high school level but only half of them completed those schools. 16 per cent of the respondents did not receive any formal schooling at all, 88 per cent of whom were females.

Mobility and Migration

A majority of the respondents from Tay Ninh in Vietnam (67%) and nearly half of those from Svay Rieng in Cambodia (47%) were born in the cross-border area. Other Cambodian respondents came from 17 other provinces while the Vietnamese respondents were from 26 other provinces of their respective countries. The most common reason cited for migrating was economic; respondents wanted to earn more money and get better jobs.

70 per cent of the respondents (63 per cent of them were female) worked in Svay Rieng throughout the year, while 10 per cent of the respondents classified themselves as seasonal workers, (76 per cent of them were female). 9 out of 10 of the seasonal workers

went back to their home provinces when there was no work in the study sites. Migrants working in the formal sector returned to their home provinces 3-12 times a year while those in the informal sector were returning home daily.

Female migrants were more likely to live with relatives on their work sites while male migrants, tended to live with co-workers. Vietnamese migrants were more likely to live alone than Cambodians.

Pandemic and Emergency Preparedness

Most of the respondents were aware of diseases that can spread to communities. HIV/AIDS and avian influenza were the diseases mentioned most. About 8 out of 10 of the respondents were worried that they or their loved ones would be infected by these diseases. Those who were not worried said it was because they protected themselves, were not exposed to it and were healthy and strong.

Migrants working in the formal sector said the first thing they would do if a disease outbreak occurred would be to seek medical help. Migrants in the informal sector said they would store medicines first. The primacy of seeking medical help during a disease outbreak among migrants who work in the formal sector indicates an awareness of or access to medical services and facilities, which is provided or at least facilitated by their employers. Migrants in informal sectors were more used to doing things and solving problems by themselves. This explains their tendency to take steps or actions that are self-initiated, rather than provider-initiated.

9 out of 10 respondents agreed it was a good idea plan for an emergency. But when asked if they had made taken any precautionary steps for a disease outbreak or natural disaster, only 60 per cent of the Cambodians and 46 per cent of the Vietnamese migrants said they did. The most common plans involved stockpiling food and water, putting aside money and making advance preparations for evacuation. In an actual emergency, the most common reaction of the migrants was to evacuate. Evacuation is preferred in situations such as floods or cyclones but in a pandemic influenza scenario, staying at home or social distancing is the best option.

Migrants were also aware of which government authority to contact during a disease outbreak or natural disaster. Identified authorities included local government departments, health services, police and emergency services. Migrants thought the best ways the government can help them during an emergency were to provide food, shelter, medicine, money and early warnings.

Access to Health Information

The three forms of broadcast and print media, television, radio and newspapers were the migrants' top and most trusted sources of news and information. When it came to health information, the top and most trusted sources were television, radio and physicians. The very low ranking of health workers and IEC materials indicates that service providers rarely had contact with the migrants at the study sites. The mobile and transient nature of migrants certainly contributes to this.

Television was also the most-widely used form of media by the respondents, with more than half of each migrant group saying they watch it daily. Except for the Vietnamese

migrants who work in the formal sector, the rest of the respondents tended to listen to the radio every day. Most of the Vietnamese migrants working in the informal sector and the Cambodian returnees did not read newspapers at all. This may be attributed to lack of money, language barriers and/or lower levels of literacy.

There is very low coverage of health education activities among migrants, across both formal and informal sectors. About 7 out of 10 respondents said they did not receive any health education/information last year. Of those who received it, around two-thirds were provided by companies and NGOs. Health/medical staff, commune officials and village health workers provided only 20 per cent of the total number educational sessions.

Language was the most commonly identified barrier to getting health information. The issue of language, whether health information was delivered in the migrants' native language or if the language used was appropriate to the migrants' level of comprehension, is an obstacle that needs to be addressed.

Lack of interest is another barrier that warrants attention. The many interpretations and implications of the phrase "lack of interest" even if focused on the context of health, reflect the varied concerns of migrants—many of which are not health-related. Whatever the underlying reasons might be, addressing this barrier is as important and critical as providing strategic solutions to the other barriers like lack of access to media, language, and literacy.

Health-seeking Behaviour

A very high proportion of migrants believe that hygiene is the key to maintaining good health. 94 per cent of the respondents said they washed their hands before eating. An average of 63 per cent always used soap when washing their hands.

There is a relatively high level of awareness of how to prevent the spread of diseases transmitted through droplet infection, such as a cold or cough, even possibly, avian influenza. The two most common means of avoiding infection from others were washing one's hands after coming in contact with an infected person and avoiding close contact with the infected person.

65 per cent of the respondents said they would go to a government hospital when they felt sick. Migrants in the formal sector preferred private physicians. This may be attributed to the fact that they have regular income and can afford to pay for private health care services. Based on the FGDs, Cambodians tended to seek medical attention at the local health centres only when they were seriously ill, and probably because of cultural reasons, often prefer to try traditional remedies and seek faith-based support first.¹⁷

Trust was the biggest factor why migrants chose certain service providers and facilities over others when ill. The Cambodian returnees were an exception to this finding. Their selection was based on the more practical reasons of cost and location.

Migrants working in the formal sector were more likely to have sought health care services compared to those in the informal sector primarily because they had more

¹⁷ Report on Focus Group Discussion Qualitative Data Collection, Pandemic Preparedness for Migrants and Host Communities Project; IOM Cambodia; December 2008.

disposable income and access to health care. About half of the Vietnamese migrants in the informal sector did not seek any health care in Cambodia last year. This is much higher than the 23 per cent of the Cambodian returnees who did not seek any health care in the same period. Most of the Cambodian returnees, 41 per cent in fact, sought health care 2-3 times last year. The main challenge is still access to services. The Cambodian returnees were self-employed and consequently, did not have the level of access to health services that employees have. However, their awareness of health service providers and facilities in their communities enabled them to seek health care when needed.

When the respondents were asked where they would go if they felt sick, the five most frequent answers were (1) government hospital, (2) government health centre, (3) private doctor, (4) pharmacy, and (5) private clinic.

However, when asked where they actually sought treatment in the last 12 months, the five most repeated answers were (1) pharmacy, (2) government hospital, (3) government health centre, (4) private doctor and (5) relatives. This indicates that self-medication is a common practice among the respondents, regardless of migrant groups. The high ranking of relatives reinforces this point. Self-medication also includes asking relatives what medicines to take during times of illness. For a variety of reasons such as lack of access to physicians, shortage of money, and low trust in public health facilities, self-medication is very prevalent in Cambodia.

Economics played a major role in the migrants' access to health services. Getting money for treatment was the most popular barrier among the Cambodian respondents and the

second most popular barrier among the Vietnamese respondents. Another economic factor—fear of loss of income, was also frequently mentioned among all migrant groups.

The schedule of the service facilities was a significant barrier among migrants in the formal sector. Most casino and garment factory workers do not work regular 9-to-5 jobs; they usually work 8-hour shifts at odd hours, with weekly or monthly rotations. More often than not, their free time does not coincide with the schedule of many public and private sector health care facilities. Pharmacies tend to be popular places to seek medical assistance partly because they are open most of the day, making them more accessible for people working odd hours.

Avian Influenza

There is very high level of awareness of avian influenza. However, in terms of accuracy, there is still a lot of room for improvement. Some of the recommended behaviour in preventing avian influenza, such as washing one's hands with soap after handling poultry, wearing masks and gloves when handling poultry and not letting children play with poultry were among the least cited answers.

The perception of risk is very low. Many people remain unaware of the symptoms and the effects of the disease because avian influenza has not received enough media attention. .

B. In light of the conclusions, the following **recommendations** are being put forward:

1. There is awareness of emergency preparedness among migrants. However, concepts about pandemic preparedness need to be properly clarified and disseminated among

migrants, the host communities, including service providers, stakeholders, gatekeepers and community leaders. This can be done through extensive information dissemination, organizing community forums on pandemic preparedness and fostering a learning environment within governmental agencies and personnel on pandemic preparedness and its related issues. Furthermore, to maximize the participation and involvement of community leaders and gatekeepers and to enhance the quality of services of the providers, they need to undergo further training and capacity-building on pandemic preparedness.

2. There is very high level of awareness of avian influenza among the migrants. The challenge is translating this awareness into a deeper comprehension of what this disease is—its nature, its risks, its prevention—and turning this into practical actions, all in the context of pandemic preparedness.
3. Making migrants and the host communities understand that pandemic preparedness is not just about avian influenza, and vice versa is very important for developing an effective pandemic preparedness strategy. Pandemic preparedness involves multi-sectoral and integrated actions involving health and non-health stakeholders. It is, therefore, important to develop an effective and migrant-inclusive pandemic preparedness strategy at the provincial and community levels.
4. A significant portion of the respondents are between the ages of 21 and 30 years old. Age has implications on developing the messages and determining and planning the range of communication activities that will be used in disseminating these messages to each migrant group. For example, messages directed at younger and single

migrants might focus on their personal well-being while messages targetting older and married migrants might emphasize the health of families as a whole.

5. The television, radio and print media are potentially the most effective channels of information dissemination to the migrants. However, differing levels of media usage among migrant groups will require distinct communication strategies and activities to ensure maximum coverage and effectiveness. For example, even if migrants working in casinos have greater access to television than the migrants selling food at a market, they are likely to watch less television than the food sellers, simply due to time constraints. Both groups, however, listen to the radio regularly.
6. Personal networks are very important elements in terms of communication activities which are excellent entry points for information and messages. Although there is the risk of diminishing accuracy as messages travel within personal networks, they still offer good value in terms of generating interest and awareness, which could lead to knowledge and behavioural change.
7. When developing educational materials and activities, the different levels of literacy standards among the migrants, along with their language skills, and their access to mass media must be given utmost consideration. There is no sense in developing a text-heavy poster if the target audience cannot read, or conducting an education session to market vendors if the language used is “too technical”, or producing a television advertisement if it is aired when migrants are working in the factories.

8. Increasing the level of interest of migrants to pay more attention to their health is another challenge that can be addressed hopefully by supporting educational activities that will promote learning and understanding the health risks and consequences of a pandemic influenza event, or get them to appreciate the value of preparing for a pandemic that goes beyond knowing which medicines to take and where to buy them. This can be done either through individual and interpersonal communication or through group discussions or community mobilization activities. The hard truth is that, it is very difficult to change behaviours. But education facilitates the process.
9. Self-medication is also a significant health-seeking behaviour that warrants attention. Although, it may not seem to be closely related to concepts associated with pandemic preparedness, self-medication has long-term effects on the perceptions of health and on the health of people. This will, in turn, affect health-related initiatives in relation to pandemic preparedness. Like the previous recommendation, this involves changing behaviours.
10. There is an obvious economic connection to the migrants' health-seeking behaviour, as shown in both quantitative and qualitative surveys. Therefore, health education activities with migrants should also be mindful and sensitive to their non-health concerns like income, family dynamics that lead to certain situations, employment, and security, among others. When preparing plans related to pandemic preparedness, the collaboration of health and non-health sectors is critical and therefore should be fostered and nurtured.