

## **HIV and AIDS Education for Displaced Burmese in Thailand: Politics, Policy and Practice**

**Ruth Tate-Campbell**

*Center for International Education, University of Sussex*

*Global patterns of migration are changing and an increasing number of populations are finding themselves in protracted situations of forced displacement, without access to basic health and education services. The accompanying increase in poverty, mobility, sexual violence, prostitution, and stigma puts displaced populations and host communities at increased vulnerability to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). This paper uses recent United Nations Educational, Scientific and Cultural Organization/United Nations Refugee Agency (UNESCO/UNHCR) guidelines to critically examine the educational provision for displaced Burmese in and around the town of Mae Sot, Thailand.*

**Key words:** *migration, HIV, AIDS, education, Thailand, Burma*

## I. Introduction

In 2005, over 44 million people were displaced worldwide due to 'conflict, violence, crisis or persecution' (UNESCO/UNHCR, 2007, p8). Patterns of migration are changing, and although numbers of forced migrants have decreased, numbers of stateless and internally displaced people<sup>1</sup> (IDPs) have risen (UNHCR, 2005). Sixty percent of refugees are in protracted<sup>2</sup> situations (ibid) that increase vulnerability to HIV and AIDS as inadequate access to education and health services, insecurity, poverty, and the breakdown of social frameworks lead to a proliferation in risky behavior (Hearn, 2008). Such factors contribute to higher HIV prevalence rates than in the country of origin and host population, increasing the discrimination refugees face in communities (ibid). Stigma towards persons living with HIV and AIDS can be a barrier to prevention and treatment due to perceptions of sexuality, gender, race, poverty, and existing prejudices within society (Parker et al. 2002). The relationship between stigma and displacement is complex: education can be considered a 'social vaccine', helping prevent HIV infection and reduce stigmatization (Kelly, 2004).

This paper explores education provision and HIV prevention amongst the displaced Burmese population in Thailand, where 140,000 live in refugee camps along the border (Thailand Burma Border Consortium; TBBC, 2009), 200,000 outside camps and over two million<sup>3</sup> are employed, the majority illegally (IDC, 2007). Within communities living outside designated refugee camps, increased mobility, language barriers and discrimination hinder access to Thai health and education services (Sciortino and Punpung, 2009). This population is of specific concern as HIV prevalence is increasing (Mae Tao Clinic, 2007). Examining HIV and AIDS education outside camps along the Thailand/Burma border is necessary to avert an epidemic.

At the level of international organizations, including UN agencies, little is known about displaced populations outside camps, who are effectively neglected. The UNHCR (2007a) needs analysis of displaced Burmese persons in Thailand excludes non-camp residents, since the UNHCR works solely with camp residents and urban refugees in Bangkok. To rectify this, the international community must analyze the root causes of displacement, and acknowledge that the complex interrelation of economic and political factors affecting displaced Burmese on the Thai border makes international support necessary for successful protection, access to services, and the provision of durable solutions. This paper first examines the relations between conflict, displacement, education and HIV, and how education can contribute to HIV prevention in displaced populations. Following this, recent UNESCO/UNHCR guidelines are used to critically examine educational provision for displaced Burmese in and around the border town of Mae Sot, Thailand.

## II. Context

### A. Burma: Political, economic and social welfare

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<sup>1</sup> IDP: displaced by violence or conflict but remaining in their own country

<sup>2</sup> Protracted is considered a situation where over 25,000 people have been displaced for over 5 years (UNHCR, 2005)

<sup>3</sup> Due to the lack of a reliable study of migrant demographics along the Thai-Burma border, population statistics stated are estimates. Figures quoted in various sources vary from 2 to 4 million total Burmese migrants living in Thailand.

Since the military gained power in 1962, Burma has deteriorated economically and socially “as a consequence of command-style economic management under military rule, [and] self-imposed isolation” (Myint, 2008, p53). The current ruling junta, the State Peace and Development Council (SPDC), sustains a regime of human rights abuses and intimidation to maintain control, including “forced labor, political and religious persecution, conscription of child soldiers and forced displacement” (IDC, 2007). Investment in services and infrastructure is grossly inadequate. The last World Health Organization (WHO) health systems ranking placed Burma 190<sup>th</sup> out of 191 countries worldwide (WHO, 2000). The resolution to spend on the military rather than services, and control and unify ethnic groups at the cost of human and civil rights has resulted in Burma’s economic and social collapse (Steinberg, 2001; Booth, 2003). Large numbers of individuals have sought refuge in neighboring countries, the majority in Thailand (Karen Human Rights Group, 2006).

### **B. Thai Legislation**

Concerned that lenient treatment will incite growing numbers of migrants, the Royal Thai Government (RTG) has neither adopted international refugee legislation (Huguet and Punpuing, 2005), nor ratified the 1951 Convention Relating to the Status of Refugees, which defines a refugee as a person who “owing to well-founded fear of being persecuted [...] is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, n.d.). Instead, the RTG uses the term “temporarily fleeing fighting,” and individuals granted UNHCR refugee status are considered “of concern to the UNHCR” (UNHCR, 2006b).

Displaced people in border towns are regarded as economic migrants, although their conditions may be less secure, with less humanitarian assistance than in refugee camps. The protracted nature of the situation affects new generations; children born in Thailand before 2003 were ineligible for birth certificates, becoming stateless, without a nationality or documentation necessary to access education or health services (UNHCR 2006b). Registration is expensive and difficult, and many people remain in Thailand illegally rather than go through this process (Lom, 2008). The RTG has modified legislation and attempted to improve migrants' access to services (Sciortino and Punpuing, 2009), but nationwide success is hampered by the concurrent implementation of restrictive measures in certain provinces, including curfews, banning meetings of over five people and owning motorbikes or mobile phones (Lom, 2008).

Whether residing in camps, Thai border towns or Burma, displaced persons share the plight of being outside their place of residence, unable to return due to fear of persecution. In up to 50% of cases, economic migrants meet the criteria to be considered refugees by the UNHCR, but only a very small proportion are recognized as such and receive international protection (Green et al., 2008). Distinctions in definitions are thus political rather than circumstantial, allowing the RTG to circumvent international refugee law with impunity.

### **C. Epidemiology**

In the 1990s, Thailand averted an HIV epidemic by implementing a nationwide public education drive to address misconceptions and risky sexual behavior (Ainsworth et al., 2003). Despite this success, the RTG recently recognized the need to change public health and education strategies

to continue to contain the epidemic, renew focus on HIV and AIDS and include new groups at risk, such as men who have sex with men and displaced populations (Medecins Sans Frontieres, 2005). The largest displaced population is Burmese, and China, Laos, India and Thailand all experience higher HIV prevalence in provinces bordering Burma, due to human trafficking, drug trade and prostitution (Khin, 2002).

Along the Thai border, the health of displaced persons inside camps is comparable to the general Thai population, in contrast with the inferior health of those outside, who lack access to services (Pleues et al., 2008). The main organization treating HIV and AIDS outside camps is the Mae Tao Clinic, which provides outreach services and coordinates community based organizations to deliver HIV and AIDS education. Around 50% of persons diagnosed with HIV are Burmese without access to health care, making the journey across the border specifically for help (Mae Tao Clinic, 2007).

The higher integration of displaced populations in urban areas puts them and the host community at increased risk of HIV (UNESCO/UNHCR, 2007). The discrimination many displaced Burmese in Mae Sot face in local schools and hospitals, and difficulty accessing such services can prevent early diagnosis, information and effective treatment (Mullany et al., 2003). There is also a lack of education regarding prevention strategies. Two thirds of IDPs have never heard of HIV and AIDS, only one third have seen a condom and have “extremely poor knowledge about transmission” UNHCR (2007, p46). Knowledge among displaced Burmese in Mae Sot is also inadequate: almost 90% believe HIV is transmissible by kissing or coughing, only 60% of men and 15% of women have ever seen a condom (Mullany et al. 2003). Such gender differences occur partly due to conservative views on women's sexuality. Until 2001 in Burma, possessing condoms was considered evidence of prostitution, and the prevailing stigma attached is indicated by the continued arrest of women carrying condoms (Talikowski and Gillieatt, 2005). These misconceptions contrast with levels of knowledge among Thais, indicating “political, social, legal, economic and physical barriers” to health and education campaigns in Thailand and a dearth of HIV education in Burma (Mullany et al. 2003, p68).

### **III. Education, HIV and AIDS and forced migration**

#### **A. Conflict, Migration and HIV and AIDS**

Refugees follow a typical cycle of displacement, moving from initial emergency to relative stability and dependence on humanitarian assistance, to durable solutions including repatriation, relocation or integration in the host community (UNESCO/UNHCR, 2007). In protracted situations such as Thailand, displaced populations stagnate at the stage of dependence on humanitarian assistance (UNESCO/UNHCR, 2007), reflecting a failure at the level of the country of origin in which conflict occurred, the host country in which policy is formulated, and engagement of the donor community (UNHCR, 2006a).

During the initial emergency and dependence phases, “poverty, physical, financial and social insecurity erode habitual caring and coping mechanisms, [and] refugees are often rendered disproportionately vulnerable to HIV/AIDS” (Spiegel and Nankoe, 2004, p21). HIV incidence rates within refugee populations can, in turn, intensify negative perceptions within host communities (Parker et al., 2002; UNESCO/UNHCR, 2007). In the case of Burmese refugees to Thailand, this occurs if women resort to prostitution, or men engage in unsafe sex and transmit sexually transmitted infections to their wives (UNESCO/UNHCR, 2007). However, Spiegel (2004) cautions against generalizing about HIV amongst displaced populations, as contextual factors affect vulnerability and the spread of disease. Displaced persons in camps may access better health care and education than in their country of origin, which decreases vulnerability. Generalizing leads to a cycle of stigma and vulnerability, as host communities believe migrants spread HIV, regardless of actual risk (Spiegel, 2004). Alternatively, integration within host communities with high HIV prevalence may lead to quicker spread of HIV. Higher HIV incidence on the Thai border suggests that factors that increase vulnerability are putting both Thai and Burmese populations at risk. Programs to reduce vulnerability are necessary to prevent the spread of HIV, and governments, non-governmental organizations (NGOs) and UN agencies have an opportunity and responsibility to safeguard the right to health and education within displaced populations in Thailand.

### **B. Education and HIV prevention**

In conflict situations, instituting health and education services is necessary to instill stability, structure and impart important life-skills (UNESCO/UNHCR, 2007). These services are a basic human right, and should include HIV education, as commitments by the international community towards achieving Education for All (EFA) include pledges to “meet the needs of education systems affected by conflict, natural calamities and instability” and create “educational programs and actions to combat the HIV/AIDS pandemic” (UNESCO/UNHCR, 2007, p13). Given that HIV and AIDS are incurable, prevention is the best method of halting their spread, and is dependent on education as a social vaccine (Kelly, 2004).

Displaced populations' educational exclusion impacts individual ability to prevent HIV initially, in the country of origin where education and health services may have been destroyed, and later, in the host country, as refugees may not have legal access to such services, be socially excluded by confinement in camps, and face discrimination or language barriers (Oh and Van der Stouwe, 2008). In countries with negative views of displaced populations, aligning efforts with national policies is essential. Failing to address refugees' HIV and AIDS education weakens similar education initiatives in place for citizens of the host country, as interaction between communities may negate preventative measures (Spiegel and Nankoe, 2004).

### **C. HIV and AIDS education for displaced populations**

Education can break the cycle of infection, stigma and exclusion, and despite the complex and context specific considerations of each situation, common components of HIV and AIDS education for displaced populations can be identified. This paper uses the most recent UNESCO/UNHCR (2007) HIV and AIDS education guidelines for refugees as a framework to analyze the provision for displaced Burmese populations living outside refugee camps in Thailand. Using this framework has limitations, as most research was conducted in sub-Saharan

Africa, and does not account for political, economic and cultural differences in Southeast Asia. Nonetheless, the shared characteristics of displacement and vulnerability make the research relevant to the present context. Furthermore, although the UNHCR does not work with displaced populations outside camps in Thailand, they are the leading organization for refugees worldwide and their framework is the most comprehensive by which to analyze a given displaced population.

#### **IV. Educational Responses to HIV and AIDS for Refugees and IDPs: The UNESCO/UNHCR framework**

The shortage of research into HIV and AIDS education on the Thai border makes it important to begin exploring the current gaps, barriers and successes in provision. The UNESCO/UNHCR (2007) framework suggests five components are essential to a comprehensive, cohesive approach to HIV and AIDS education for displaced populations:

##### **A. Policy, management and systems**

Coordination, mainstreaming, and integration of HIV and AIDS policies and interventions, management and systems at country and organizational levels is essential; governments should address refugees specifically in education and health policies.

##### **B. Quality education, including cross-cutting principles**

Community organizations should be involved in assessment, planning, implementation, and monitoring and evaluation of programs to ensure their relevance. Programs must be designed to meet the needs of individual groups (ensuring community participation at all levels), as well as to ensure a safe learning environment that protects the emotional and well-being of learners.

##### **C. Content, curriculum and learning materials**

Context, culturally-specific, and age appropriate factors should be considered and education should tackle discrimination issues. The curricular approach taken to deliver HIV and AIDS education<sup>4</sup> content that will be covered within the curriculum, teacher training needs, and resources required should be clearly defined.

##### **D. Educator training and support**

Educators should be given the appropriate knowledge to instruct, in formal and non-formal settings. Training received by educators should be relevant to communities, and meet home country requirements. In addition, programs should foster skills to help learners to make informed decisions about behaviors and relationships.

#### *5. Approaches and entry points*

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<sup>4</sup> The approach can vary from HIV and AIDS education being taught as a stand-alone subject, covered within another main subject (such as Natural Sciences or Health Education) or taking a cross-curricular or 'infused' approach that embeds HIV and AIDS education within several subjects (explicitly or implicitly).

A range of entry points should be used to make maximum use of resources and ensure sustainability.

## **V. Methodology**

As little published literature on HIV and AIDS education for displaced Burmese populations living outside camps in Thailand exists, staff at the UNHCR, International Organization for Migration (IOM), Mae Tao Clinic, and a human rights NGO were contacted for information. This was provided in email communications between March 12 and April 9, 2009. Staff requested not to be named for reasons of personal security. 'Participant A', from the human rights NGO, requested the organization remain anonymous, so the security of other staff members and the organization was not compromised. 'Participant B' works at the Mae Tao clinic in the Adolescent Reproductive Health Network (ARHN) project. 'Participant C' is based at the UNHCR Mae Sot office and 'Participant D' works on migrant health issues at the IOM in Bangkok. Participants B, C and D did not consider it dangerous to reveal the name of their organizations. The insights represent a small cross-section of organizations and experiences rather than a comprehensive overview. Nonetheless, the answers were invaluable in reflecting experiences from the field, and together with the literature available and personal experience have formed the basis for the analysis in the next section.

## **VI. Provision in Mae Sot: Critical Analysis using the UNESCO/UNHCR Framework**

### **A. Policy, Management and Systems:**

Several criticisms can be levied at this component of the UNESCO/UNHCR framework. First, it seems unrealistic to expect countries to budget for HIV education of displaced populations, which are in the majority of cases hosted by developing countries lacking this capability<sup>5</sup> (UNHCR, 2006a). Although the RTG's selective adherence to legislation is far from ideal, it cannot be solely responsible for the integration of such a sizable displaced population. Thailand does not possess the capacity or resources to provide a cohesive response to HIV and AIDS education for an additional two million people. Greater involvement of international organizations, including the UNHCR, in lobbying the Burmese junta, may eventually help to create a situation where repatriation is possible. Second, it assumes that refugees will want to access education in the host country, when issues in practice are more complex. Some Burmese parents, who envisage their children growing up and working in Thailand, prefer to enroll them in Thai schools, where they can learn the language and culture (Participant A). However, many prefer to send their children to unofficial migrant schools where native language and culture are instructed (Guinard, 2006), and they do not face discrimination by the Thai community (Participant D). The Thai Ministry of Education (MoE) supports EFA initiatives, and in order to work towards universal primary education has made provision for migrant schools, such as translating the Thai curriculum into Burmese and working towards recognizing qualifications (Guinard, 2006). However, dissonance in policy and attitudes with the Ministry of Interior and local police make the situation for these schools precarious (Participant A).

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<sup>5</sup> As Thailand is a lower-middle income country, it is considered 'developing' within the paper, in accordance with the World Bank's classification of all lower and middle income countries (World Bank, 2009)

The majority of Burmese parents' decision not to send their children to Thai schools is despite legislation implemented by the RTG in 2005 to fund non-Thais to access the national schooling system regardless of legal status (Sciortino and Punpuing, 2009). Education is central to HIV prevention and Thailand's efforts to expand access to basic education are a positive step. Nonetheless, a large proportion of children still fail to access basic education. Although accurate figures for the population in Mae Sot are unavailable, the Thai MoE reports that over 30,000 Burmese migrants were enrolled in Thai schools in 2007, which remains a small proportion of the total population (Sciortino and Punpuing, 2009, Participant D). Coordination and capacity building are necessary at national, regional and school levels, as the RTG lacks the finances to implement the 2005 initiative, with almost half of schools not receiving the promised funding for enrolled pupils, and over ten percent unaware of the new legislation (Sciortino and Punpuing, 2009).

The inclusion of refugee and migrant populations in the RTG's 2007-2010 HIV and AIDS policy strategy further reflects its commitment to consider displaced populations in national health and education plans. The policy promises increased access to antiretroviral treatment (ART), and although education is not explicitly cited, pledges to "build an understanding and awareness on HIV/AIDS and sexual activities" (National Committee for HIV and AIDS Prevention and Alleviation, 2007, p40). However, ambiguous targets could make monitoring, evaluation and holding the RTG accountable difficult, and the creation of a policy for refugees and migrant workers seems paradoxical considering Thailand does not recognize refugee status or adhere to international conventions. Policy has not translated into practice and ART remains excluded from free treatments available (Prevention of HIV/AIDS Among Migrant Workers in Thailand; PHAMIT, n.d.3). Thailand recently secured funding for ART for non-Thais from the Global Fund for AIDS, Tuberculosis and Malaria, but provision is restricted to 2,000 places and excludes non-camp populations as only registered refugees are eligible (Participant C).

The lack of a single health and education monitoring system for displaced communities outside camps compounds the lack of coordinated response. The Mae Tao Clinic holds the most comprehensive health systems database, which remains inadequate by only comprising patients (Participant B). Individual organizations/ clusters of organizations partake in monitoring, but the approach is fundamentally people-driven, relying on individuals rather than systems. Organizations operate separately, without an overall HIV and AIDS education planning framework, or specific programs for IDPs (Participant B). This piecemeal approach could lead to resource dissipation as organizations unknowingly replicate or duplicate programs.

Barriers to effective HIV education include difficulties accessing populations and inadequate funding for displaced populations health and education in Thailand (Participant B). Programs must be expanded to access all populations, and the Burmese government lobbied to increase spending on health and education (*ibid*).

## **B. Quality Education**

Providing HIV and AIDS education for children and adolescents before sexual debut is essential (UNESCO, 2008). At the Mae Tao Clinic, HIV voluntary counseling and testing are provided, in addition to numerous community-led education programs. One such program, the Adolescent Reproductive Health Network (ARHN), comprises nine organizations which share the objective

of implementing community based reproductive health training for displaced people along the border. Adolescents are trained as peer educators before introducing topics in communities. The curriculum is participatory, uses gender sensitive approaches, and covers key areas of knowledge in addition to negotiation and counseling skills (unpublished curriculum, ARHN). Easily monitored assessment procedures are used, testing knowledge and attitudes before and after interventions (unpublished evaluation matrix, ARHN). Training is provided in various languages to reach different ethnic groups (Participant B). Programs also operate for adults and families; Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT) provides life skills training for children, reproductive rights training for adults, and distributes educational materials. Significant increases in condom use amongst casual partners from 2003-2008 have been reported following interventions (PHAMIT, n.d.2; Pinyosinwat, 2009). ARHN and PHAMIT impact positively upon displaced populations, and meet the UNESCO/UNHCR (2007, p19) criteria for quality, being “rights-based, proactive and inclusive, with curricula and instructional approaches that are gender-sensitive, scientifically accurate and culturally appropriate.” However, the lack of an overall monitoring framework makes an assessment of quality and replication of HIV and AIDS education programs across organizations currently impossible.

The lack of stable and secure learning environments is a significant hindrance to quality education as migrant schools are liable to be shut down, students risk attack or deportation, and high levels of gender based violence persist. This is partly due to stigma in Thailand and the “fear factor” associated with displaced Burmese people creating low community tolerance (Hearn, 2008). UNICEF and the IOM are launching programs aimed at reducing negative stereotypes (IOM, 2009), and the RTG must address this key component in HIV education and prevention. Although good quality practice and programs are in existence, a more cohesive approach is required to overcome stigma and ensure programs are not duplicated.

### **C. Content, Curriculum and Learning**

A strength of HIV education programs in Mae Sot is the availability of materials in different languages, making them easily accessible to local organizations and communities. Reproductive health curricula and educational resources are available online in Burmese, from organizations such as PHAMIT (n.d.). Little published literature on formal curriculum elements in migrant schools in Thailand exists, since education is administered by individual organizations and communities. Together with the language barrier, this makes it difficult to comprehensively analyze the quality of content, curriculum and learning of HIV education in Mae Sot in the present paper. Despite these limitations, Participant B provided AHRN curricula for analysis. ARHN methods are participatory, in the hope that similar strategies will be used in communities. Materials are available in different languages, developed in line with community needs and tackle issues of discrimination and stereotypes (Participant B). Assessing how AHRN peer educators put knowledge into practice is difficult, as the workshop setting is non-formal. The ARHN documents initial peer educator training, but implementation varies depending on the community and peer educator's choice (ibid).

### **D. Educator Training and Support**

As with curriculum materials, resources are only available in the language of instruction, and therefore inaccessible for the current paper. The AHRN program provides peer educators with

week-long pre-service training programs, in which they are transmitted the skills and knowledge previously outlined in participatory workshops. Further support is provided every three to six months in follow up visits, aimed at assessing the use of skills and knowledge, and address difficulties encountered (unpublished AHRN assessment matrix). Each organization has representatives present at annual meetings, when progress and challenges are discussed and curricula updated, with changes then communicated to peer educators (Participant B).

Difficulties accessing displaced populations are a significant barrier to providing HIV and AIDS education; implementing outreach services is challenging, particularly amongst IDPs (Participant B). The Mae Tao Clinic works with displaced communities to devise ways of accessing populations on the Burmese side of the border, providing qualified staff in the Backpack Health Worker Team project (BPHWT; Wells, 2009). BPHWTs are trained by senior staff on skills from basic first aid to surgery. Missions within Burma are undertaken at considerable personal risk, as the SPDC considers treating IDPs equivalent to supporting the enemy (ibid). BPHWT aims to provide sustainable solutions to access, and now reaches an estimated 140,000 IDPs in Eastern Burma (BPHWT, 2009).

UNESCO/UNHCR (2007) state that providing training for non-formal educators (such as community and religious leaders) involved in delivering HIV education programs is essential. Currently, leaders' opposition to reproductive health education on religious and cultural grounds is one of the most substantial barriers to HIV and AIDS education for displaced Burmese (Participant C). This makes their inclusion even more indispensable to address the lack of HIV knowledge. Several projects, such as Mobile Obstetric Mobile Health Workers (MOM), include local leaders in planning and implementing reproductive health and contraception education but do not cover HIV and AIDS (Mullany et al., 2008). An expansion of such projects to include HIV education is needed, to increase the support of community leaders, the impact of existing programs, and reduce local stigma.

### **E. Approaches and Entry Points**

Providing a range of approaches and entry points is essential to ensuring coverage, continuity and sustainability of educational programs (UNESCO/UNHCR, 2007). Community-based learning is an increasingly popular method for providing HIV and AIDS education in and around Mae Sot. Sexuality education takes place in some migrant schools, but the lack of monitoring systems make it difficult to assess the extent and quality of programs (Participant B). Mae Tao clinic staff deliver adolescent health education at schools using ARHN peer educators to deliver the curriculum in local languages, covering topics including sex education, HIV and AIDS (Mae Tao Clinic, n.d.). Peer educators are also used by World Vision to teach reproductive health skills to young, single, newly arrived Burmese women (PlusNews, 2007). Stigma remains a barrier to learning, as many women associate HIV and AIDS knowledge with prostitution, promiscuity and drug use (ibid). Women are compensated for time taken off work, but employers' reluctance to allow employees to attend affects participation (ibid). Peer educators may be the most effective way of accessing difficult to reach members of the community to reduce stigma and improve knowledge, dispelling misconceptions that only promiscuous or drug taking people need to know (Theede and Isarabhakdi, 2007).

Stigma also affects condom use, which PHAMIT is increasing by improving knowledge, changing attitudes, and ensuring availability and accessibility (PHAMIT, n.d.2). PHAMIT aims to overcome the fear of arrest and deportation prohibiting displaced populations from traveling to purchase condoms (ibid). Through a combination of condom boxes and outreach services, condoms are now accessible at over 1,500 locations. Embarrassment is minimized by carefully selecting locations, but traditional values still prevent adolescents from openly taking condoms, and certain groups, including those in long term relationships that are not necessarily monogamous, are less likely to use them (PHAMIT, n.d.2). Work to combat stereotypes and increase access to condoms is taking place, but time and increased exposure are needed before all groups use condoms and are at ease with the idea.

Outreach services are provided in school health and feeding programs operating through the Mae Tao clinic. The clinic runs a school for 500 pupils, which its staff's children may attend (Mae Tao Clinic, 2007). The Migrant Assistance Program foundation and World Vision Foundation of Thailand have drop-in centers in Mae Sot, aimed at displaced populations on the border working in low paid factory jobs. The centers have libraries lending educational reproductive, HIV and AIDS materials, and run educational workshops and AIDS awareness sessions (PHAMIT, n.d.). Further information is distributed by PHAMIT, ARHN and the Mae Tao Clinic in different languages. An onsite resource center is available for health workers and patients, and clinic practitioners give each patient health education (Mae Tao Clinic, 2007). To involve the community and increase awareness, the clinic sponsors several yearly health campaigns, for example World AIDS Day (Mae Tao Clinic, 2007). In this way, organizations provide a secure environment, mixing information and education with community activities.

## **VII. Conclusions**

Based on the analysis of provision using the UNHCR framework, it is evident that organizations are providing sustainable, context relevant, participatory education programs to tackle HIV and AIDS issues in local communities in and around Mae Sot. Furthermore, the RTG's inclusion of displaced populations in health, education policy, and planning at national, regional and local levels is encouraging. Nonetheless, notable gaps in research and provision exist, particularly with regards to those residing outside refugee camps, who remain hard to reach and without legal access to ART. High levels of exclusion due to language and cultural differences prevent access to Thai schooling and health systems, and are intensified by widespread stigma towards migrants and HIV.

Education strategies in Thailand must be targeted at reducing discrimination towards displaced populations and HIV. To facilitate this, the factors that limit or increase HIV transmission and risks to host communities must be better understood in national and regional contexts. International, national, regional, and local level policies and strategies should be coordinated and mainstreamed for effective resource management. The international community must support the RTG in building capacity to effectively scale up and monitor programs. Ultimately, the RTG and international community must engage in a concerted effort to address the economic, civil, social, and political oppression in place under SPDC rule, otherwise educational efforts will provide temporary relief rather than break the cycle of abuses that cause the mass migration of Burmese to Thailand.

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