CHAPTER V

DISCUSSION

5.1 Individual Characteristics

The majority of the respondents were youth and young adults with the age of 18 to 35 years old. Most of them were Burmese and Dawei. The ratio of married to single was about 1.2 and the education level of the majority was in low and middle level. Around half of them stayed in Ranong for 1 to 5 years. These figures were nearly the same with the data from Muang District Public Health Office. Factory workers, seafood processing workers and fishermen were the majority in this study. Around half of them have 1,500 to 3,000 Baht as their average net household income. The percentage of registered workers was 32.2% of total respondents which was slightly higher than the figure (~25%) estimated by Muang Distric Health Office in 2007. Regarding the Thai language skill, 50% of the respondents can speak basically while 34.8% cannot speak at all. 34.5% of the total respondents stated they have underlying health problems. 52.3% and 34% of the migrants had smoking and drinking habits within 3 months before the survey.

There is no association between age and utilization of health care services. But it is seen that migrants more than 45 years of age use health care services more. It may be due to the fact that they take care of them selves more as they grow older.

The results showed that more women than man were going to the health centers. This finding is different from the studies done in Bangladesh (Ahmed, 2005) where it was found out that probability of going to allopathic is less in females. In Myanmar culture, women are not regarded as socially inferior. They are usually given

equal chances. In terms of income, both men and women are working in this study and so there is no reason to suppress the women due to being dependent economically. Fosu (Fosu, 1994) stated that not being able to overtly show pain or emotions, such as fear about an illness, hinders men from feeling psychological relief as well as manifesting it in the medical encounter. Other typical problems are that men attend doctors late so as not show their weaknesses, or do not comply with health advice that implies a change in habits if they are considered 'feminized' This explanation also suits the situation in this study.

Ethnicity and religion has no significant association with health seeking behaviour. It is different from the study of Isarabhakdi (Isarabhakdi, 2004) in which an association is found between ethnicity and going to the health centers. Marital status has no association with health seeking behaviours. But it can be seen that married migrants were using the health services more than others. It is also supported by the finding that migrants who discussed their health problems with their spouses visited the health centers more. In Myanmar culture, couples usually share or discuss their problems and are taking care of each other and it is seen here. This finding is compatible with the survey done in Myanmar in which the decision making processes for contraceptive use are usually made by both partners (World Health Organization, 1997).

The results show that the more educated the migrants are, the more they would use the health services. This is in accordance with a study done in Bangladish (Ahmed, 2005). Regarding the duration of stay in Ranong, it is seen that the longer the migrants were in Ranong, the more they visited the health centers. It might be due to the result of trusting the health centers more or gaining registration status to work

and stay. It is also supported by the fact that they visited to Government hospitals more as their duration of stay became longer.

The Registration status has significant association with health seeking behaviours. The registered migrants were more likely to use health services because they can go everywhere freely. It was noticed in Ranong that many of the migrants were unregistered and the thing they care most is their illegal status. These migrants were afraid of going to other places outside their home and workplace, they tried to hide when they saw a police as they fear of deportation. This makes them to visit health centers less. Isarbhakdi and Guest also stated that Migrants who move often have less access to services than non-migrants. Moreover access to services is usually more limited for international migrants, especially illegal migrants (Isarabhakdi & Guest, 1998).

The benefit obtained by the registered migrants is that they can visit the Government hospitals under 30 baht scheme. With this, whenever they go to the Hospital, they just need to pay 30 baht. Therefore, the registered migrants were more likely to go to the Government hospital than private clinics when they have health problems. It was also seen that some employers were taking responsibility to pay the health care expenses of their non-registered workers. But they were more likely to go to the private clinics.

There is no relationship between Thai language skill and health seeking behaviour. This finding is not consistent with a study by Ishrabhakdi (Isarabhakdi, 2004) in which it is found out those Myanmar migrants who are able to speak Thai use government health services to a greater extent than those who cannot. It is also differ from a survey on the health vehaviour of the Chinese in Hull, where one of the

main reasons identified was communication difficulty faced by many Chinese due to language problem (Watt, Howel, & Lo, 1993). Being a border province which is very close to Myanmar and presence of a lot of Myanmar migrants, hospitals and clinics usually have translators who can speak both Burmese and Thai. Thus, language is not a barrier in using the health services.

The results show that current occupation has significant relationship with health seeking behaviour. Apart from fishermen, migrants in other occupations tend to go more to the health centers for their health problems. Being fishermen, they were usually out in the sea for a long time and in addition to this, they all are men and so they were more likely to ignore their health problems.

Health seeking behaviours has no relationship with average net income of the household. This finding is not consistent with findings from (Shaikh & Hatcher, 2004) and (Nayab, 2005) where their studies found out that income significantly influenced the health seeking behaviours. Moreover, it is surprised to find out that as the net income increased, the percentage of going to the health centers decreased. It could be because the migrants with high net income usually were fishermen who were single, who usually tend to ignore their health problems.

The migrants who do not smoke or drink go to the health centers more. It could be because they were taking care of their health by avoiding the unhealthy behaviours and consulting with professionals for their health problems. Migrants with underlying health problems were visiting the health centers more which show that they were more aware of their health due to these health problems.

Living and Working conditions

Regarding living and working conditions, half of the migrants were staying in the work compounds while another half in rent apartments. Most of their places had only one room with 2 to 3 doors and windows. The majority were staying together in a place with 1-5 other migrants. 60% of them had latrines attached inside their houses but 40% were sharing toilets with others. Around two third of the migrants had to work more than 8 hours per day and more than 90% were working more than 5 days a week.

Place of resident has significant relationship with health seeking behaviour while number of people staying together in one house has not. Migrants who were lodging in the work compound were more likely to use the health services because the work compound is like a small Myanmar community, where migrants can share news and information about the health services. Moreover, they can get more social support from each other when they have health problems.

The findings show that migrants who were working less than 8 hours or who had no fix working hours were visiting health centers more than doing other self care activities. It is because these migrants were more convenient to go to the health centers than the migrants who had longer working hours.

Health problems

The top three minor health problems reported by the migrants are cough/ running nose, headache/dizziness and abdominal pain. The top three major health problems include gastrointestinal problems, injury, pneumonia and other respiratory problems. These reported illness are similar with the findings done on Myanmar

migrants in Kanchanaburi province (Isarabhakdi, 2004) except malaria because Kanchanaburi is a place with the highest prevalence rate of malaria. These health problems should gain more attention from health care providers.

Environment, occupation and migrants' health

The top three minor health problems reported by the migrants are cough/ running nose, headache/dizziness and abdominal pain. It might be due to their working environments where they have to contact with water and ice the whole day and could also be due to their long working hours.

The top three major health problems include gastrointestinal problems, injury, pneumonia and other respiratory problems. They could also be linked to the occupations. In addition, joint pains which ranked number 4 in both minor and major health problems could be due to high amount of physical labours.

5.2 Accessibility to health care services

The results indicated that around half of the migrants would not go to the health centers until their conditions become worse. This is in accordance with a study in Thailand on Myanmar migrants which stated that many migrants fail to seek health care services or wait until their health deteriorates considerably, which often leads to life threatening consequences (Caouette, Archavanitkul, & Pyne, 2000). It is seen from the results that there is not much difficulty in accessing the health care services. And most of the migrants were satisfied with the health centers they visited. (Scragg & Maitra, 2005) also stated in "Asian Health in Aotearoa" that most Asian people (92%) were very satisfied with their primary health care doctors at their last visit.

Time taken to travel to health center has significant relationship with visiting the health centers. But it is surprised to find out that migrants who stated it took longer time to get to the health services visited more. The traveling costs show the similar result too. This finding is differing from a study in Cambodia where health-centre utilization declined as the distance increased (Yanagisawa, Mey, & Wakai, 2004). It might be due to the fact that some migrants were staying far from the center of the town yet they prefer to visit the health centers.

Consultation fees and opening time are also associated with health seeking behaviours. Migrants who think the consultation fees are not expensive for them would go more to the health centers than doing other self care activities and vice versa.

When making a comparison between Government hospital and private health centers, it is found out that the migrants have to pay more consultation fees at the private clinics and they have to wait for a long time in the Government hospitals due to overcrowding.

5.3 Health seeking behaviours

Most of the migrants would often buy drugs from drug store if they think their health problems are minor. Drug stores are often the first and only source of health care outside home for a majority of patients in developing countries (Kamat & Nichter, 1998). Purchasing drugs from drugstore is also very convenient for them. (Marsh, et al., 1999) stated that the quick and friendly service, the proximity to home, the long opening hours, the ability to send a messenger to purchase the drugs, the ability to choose affordable drugs and the possibility to buy drugs on credit reinforced

the people to buy drugs from the drugstores. Some minor illness like cough and cold, mild body pain in this study, self care may be effective and practical. But, self-care also involves risks such as incorrect self-diagnosis, absence of knowledge of alternative treatments, irrational use of drugs including selection, incorrect dosage and duration as well as side-effects and neglect of interactions with other drugs (Chang & Trivedi, 2003).

87% of migrants in this study went to the health centers when they think they have major health problems. A study done in Kanchanaburi province showed only 66% of migrants was reported to go to the health centers (Isarabhakdi, 2004). It is possible due to the fact that the Kanchanaburi study access whether the migrants use health centers or not only 1 year prior to the survey.

It can be seen that Private clinics are the preferred than Government hospital and NGO clinics. This finding is supported by a study done by (Isarabhakdi, 2004). It is stated in this study that migrants are likely to use private health services largely because these clinics are convenient to access in terms of time and transportation. In private clinics, they do not need to wait for a long time to see the doctor, as they would when using government hospital services. Moreover, private service providers do not ask for migrants' identification cards or about their backgrounds. These findings seem to be very similar with this study.

It would be interesting to find out why migrants preferred to go to the private clinics though they stated that the consultations fees are more expensive there. The results show that duration of stay in Ranong, occupation, registration status, and presence of health insurance were associated with the choice of health centers. As stated above, the longer they stayed, they would obtain legal status and also the health

insurance. Thus those migrants were likely to go more to the Government hospitals. Regarding occupation, fishermen would not usually go to the health centers but they seemed to go more to the private clinics when they have major health problems as most of them do not have a legal registration status. Migrant workers in plantation were usually staying here for quite a long time and many of them were legal migrants. It could be the fact that they were using more Government health services. Moreover, the researcher also noticed some facts regarding the preference of private clinics during the informal discussions with the migrants. Registration status is what the migrants care the most. Without this status, they were afraid to go to Government places including the hospital. They also complained about the long waiting time at the Government hospital. In private clinics, they do not need to wait for a long time. They were also afraid of hospitalization when they go to the Government hospital. The migrants also have some bad attitudes toward the Government hospital although they did not express it during the interview. Many of them said that when registered migrants went to the Government hospital, the low quality drugs will be prescribed to them as the hospital only received 30 Baht from them. They said that private clinics were using better quality drugs and also give more injections than the Government hospitals, and therefore, their health problems disappear within a short time.