CHAPTER I

INTRODUCTION

1.1 Background

The movement of people is not a new phenomenon throughout the world population's long history. Significant fluctuations in the volume and direction of the population movement have occurred in the past and are expected to continue in the future. For example, international population movement either within or from Asia was little from the early 1950s to early 1970s. After that period, the flow of migration from Asia increased especially to the oil-rich countries of the Middle East (Skeldon, 2000). After the Gulf conflict in 1990/91, there was a shift in direction of population movement towards destinations within Asia and particularly countries exhibiting rapid and sustained economic growth such as Japan, Hong Kong, Taiwan, Korea, Singapore, Malaysia, Brunei Darussalam and Thailand (Arifin, Ananta, & Punpuing, 2005).

Migration can be forced or voluntary. It may be prompted by the need to flee a perilous situation or by the promise of a better life elsewhere. Factors pushing people to leave their homes include human rights abuses, poverty and lack of human security, lack of economic development and employment prospects, inequalities between and within countries, population growth, environmental degradation and natural disasters. Factors pulling migrants towards new countries include labour shortages and demographic decline, which hold out the promise of work and a better life; faster, cheaper and, in some cases, safer communications and transport systems; existing migration networks; and the possibility of sending money back to the country of

origin to support immediate and extended family (United Nations Country Team in Thailand, 2005).

Migration is growing and increasingly visible. According to the International Labour Organization (ILO), an estimated 90 million migrant workers live and work outside their country of origin (Amnesty International, 2006). International migration within Asia has also increased over the last three decades. This is primarily a result of widening wage differentials and labour demand and supply, and partly due to more political freedom (Archavanitkul & Guest, 1999). Nowadays, migration has become a widespread and persistent phenomenon that is changing the structure of family units, communities and societies in our modern world (Lu, 2008).

Health problems of migrants

From an economic perspective, migration often permits an individual to improve his/her economic status and the society to distribute human resources. Human capital is transferred from areas of surplus labour and low wages to areas where labor is scarce and wages are high (Hugo, 1993). However, migrant and refugee populations in many countries constitute a marginalized sector of the population because they are impacted by factors that cause inequalities in numerous dimensions of social life such as race/ethnicity, poverty, illiteracy, gender and class. Migrants, refugees, and women in particular are often considered vulnerable because of their exposure to risk factors (Ioannidi-Kapolou, 2007).

Migration exposes people to health risks related to discrimination, loss of status, and abusive working conditions at host countries (Piper, 2005). Despite the heterogeneity between migrant populations in terms of origin, socio-economic

position, age, sex, culture, religion and reasons for migrating, collectively, migrants may share commonalities in their health needs (Gushulak & MacPherson, 2006); for example, increased vulnerability of migrants to infectious diseases, change in lifestyle and the diseases of affluence (diabetes, heart disease, cancers) is of major concern (Rafnsson, 2007). Some infectious diseases were found more prevalent among migrants, mainly due to the poor hygiene in living conditions. Living arrangement, living conditions, and health behavior are found highly related to the incidence of infectious diseases. The poor living condition and unhealthy practices chronically harm the health of migrants and increase the chance of infection of certain diseases (Zheng & Lian, 2005). Moreover, migrants may have higher morbidity because of differences in disease prevalence at the place of origin, the psychological and physical stress of moving, and the adaptation to the new environments (Arifin, et al., 2005). But in general, migrants, highland people, and other mobile populations often find it difficult to access basic social services, for example health information and services including reproductive health, vaccinations and primary health care (United Nations Country Team in Thailand, 2005).

Therefore it is without question that migrants are a vulnerable group. Migrant populations are likely to have unmet health needs. They may face language and cultural barriers. They may face discrimination. They may be locked into menial jobs. They may leave their homes only to find a bleak future (Dr Margaret Chan, 2007).

Migration in Thailand

Due to its geographic location in Southeast Asia, its open economy and its rapid development, Thailand is a country of origin, destination and transit of migrants.

The large economic disparities between Thailand and some of its neighbours make it an attractive destination country. While a significant amount of Thai workers left for overseas employment, those who stayed preferred not to do the dangerous, difficult and dirty jobs. Thus, foreign migrant workers accepted the jobs that Thai nationals did not want, especially in fisheries, construction work and farming. Some female migrants were employed in industrial and service sectors. They worked in factories, as domestic workers and in the entertainment business (Arifin, et al., 2005).

It is estimated that more than two million migrants in Thailand are working and contributing to Thailand's economy. While Thailand's legislation does not permit legal migration of unskilled workers, in 2003, the Ministry of Labour adopted new measures to enhance the management of irregular migration. Starting in 2004, the Thai Government has given the opportunity to irregular migrants from Cambodia, Lao PDR and Myanmar to regularize their status through country-wide registration processes administered by the Ministry of Interior and the Ministry of Labour. As of July 2004, 1,284,920 migrants from Cambodia, Laos and Myanmar had registered with the Ministry of Interior and 849,552 had work permits from the Ministry of Labour which also entitled them to health insurance under the Kingdom's "30 baht scheme". In addition to the registered migrants, it is estimated that Thailand also hosts at least 1 million unregistered migrants who also need the protection of labour laws and social services (United Nations Country Team in Thailand, 2005).

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Cross-Border migration between Myanmar and Thailand

The Thai-Myanmar Border is approximately 2,837 kilometers long with nine Thai provinces located next to Myanmar, namely, Chiangrai, Chiangmai, Maehongson, Tak, Kanchanaburi, Ratchaburi, Prachuabkirikhan, Chumporn and Ranong. Although there are only six official border-crossing points, there are countless others that the government cannot control because they are located in mountainous and/or heavily forested areas. Myanmar migrants in Thailand generally come from several ethnic minority states in eastern Myanmar, including the Karen, Kayah, Mon, and Shan states; and from Bago and Tanintharyi (Tenasserim) Divisions. Burmese migrant workers make up approximately 80% of migrant workers in Thailand; Lao and Cambodian workers are the other two largest groups of migrant workers there. Hundreds of thousands of Burmese migrant workers are employed in various sectors of Thai industry, including fisheries, manufacturing, domestic and construction work, hotels and restaurants, and agriculture (Amnesty International, 2005).

Registration is the basic requirement for the job and life security in foreign country. Being a registered worker has a guarantee to better quality of working and safer living condition, and higher income level. Migrant workers with no registration are at risks of exploitation, job insecurity, fear of arrest and deportation (Khine, 2007). Illegal migrants have to cope with many stressful problems in their daily life with the absence of protection by Thai labor law (Chantavanich, Vangsiriphisal, & Laodumrongchai, 2006). Regarding illegal status, unfair wages, improper working and living condition, fear of arrest and deportation, lack of access to the social services are the major problems they have to encounter throughout their stay in

Thailand. Yearly registration scheme under the current migration policy of Thai government is the only one approach to temporary legal status for migrants who had entered through border as undocumented (Khine, 2007).

Health condition of migrant workers in Thailand

Migrants are different from other communities due to the nature of their background. The health care problems of migrants are more because of illiteracy, widely spread communities, and poor sanitation. A number of measures are undertaken by Government of Thailand to improve the health status of migrants. Despite this, they still have a lot of health problems.

Approximately, 96.9 percent of immigrant workers who work in Thailand have poor daily living. They are stressful and anxious due to their life difficulties (Tutchananusorn, 2000). They work in unsafe environments, doing hard-risky-dirty work, having long hours at workplace, being in unhealthy surroundings, are unfairly paid and are also inequitably treated. These factors cause both physical and mental health problems to them (Kaekprayoon, 2003). Many of these migrants live in very cramped living conditions with poor sanitation, which facilitates the spread of communicable diseases.

Infection rates are increasing among migrant workers and mobile populations, including rural-urban migrants and young people who migrate nationally or internationally to study. Cross-border migrants are doubly vulnerable (United Nations Country Team in Thailand, 2005). They may be prone to greater health risks than non-migrants if they lack knowledge about appropriate health behaviours, as well as if they cannot access health care services (Isarabhakdi, 2004).

Thailand health services for migrants

In its effort to improve the health conditions of migrants in the country, the Ministry of Public Health has strengthened its policy on health prevention and communicable disease control for migrants. This will be achieved through decentralized implementation of the Health Service Plan, where the provincial and district health authorities can plan and implement appropriate health interventions on communicable disease control, health prevention and promotion to migrants. Health examinations are given to all migrants upon registration for work permits, together with their compulsory participation to the National Health Insurance Plan that ensures their access to basic health services in the public health facilities. In addition to this, the Ministry of Public Health systematically collect, organize and share relevant immigration data to all government agencies responsible for migration and migrant workers (Kittipavara, 2004). But while registered migrant workers have access to government health services, the large number of unregistered migrants experience financial, security, cultural, language and geographic barriers in obtaining health services. The mobility of the population, combined with access barriers, contributes to increased morbidity and mortality (Ministry of Public Health Thailand, 2007).

1.2 Rationale of the study

Health is a fundamental and inevitable part of all population movement and resettlement. Whether the health of people who move is promoted and protected can affect how receiving societies cope with migrant's needs (Arifin, et al., 2005). Maximizing the potential contribution of migrant populations, and their

offspring, requires that their health is as good as possible and their access to health services is facilitated (Rafnsson, 2007).

As all people do, migrants carry with them the health "footprints" of the countries and social environments they come from, and since in general economically motivated migrants tend to move from poorer to economically more developed countries, a proportion of them can be expected to carry health profiles associated with poverty (Carballo & Mboup, 2005). Therefore the public health significance of undocumented migration has become a major concern to the Ministry of Public Health, especially in the control of communicable diseases, reproductive health services, environmental health and sanitation, demand and burden upon the public health services (Kittipavara, 2004).

Health care seeking is a central issue in all kinds of morbidity, since the duration of symptoms increases the probability of severe morbidity and harmful sequelae (Grover, Kumar, & Jindal, 2006). Proper understanding of those health seeking behaviours could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts (MacKian, 2003).

To develop a rational policy to provide efficient, effective, acceptable, costeffective, affordable and accessible services, it is important to understand the drivers of 'health-seeking behaviour' of the population in a complex health care system. This relates both to the public as well as private sectors. Investing in health with the right understanding, the right approach and the right plan should be the point of advocacy (World Bank, 1993). This necessitates a strong need to understand the demand side to need to change user behaviour, and that is the only way to expect improved health outcomes (Rogler & Cortes, 1993); (Standing, 2004).

In spite of such concerns, studies on the specific determinants of health seeking behaviours of Myanmar migrants are scarce. Consequently, in order to better understand the situation of cross-border migrants in Thailand, this study focused on health-seeking behaviours of Myanmar migrants. They are an important group in labor sector, and can perform multiple roles both within the household and the community. The findings in this study will help health care professionals manage the factors that either benefit or burden the migrants' health seeking and provide evaluation feedback to health care policy makers.

The study area: Ranong Province, Thailand

Ranong is one of the southern provinces of Thailand, at the shore to the Andaman Sea. Neighboring provinces are (from north clockwise) Chumphon, Surat Thani and Phang Nga. To the west, it also borders to Kawthaung Province, Union of Myanmar. The province is the least populated province of Thailand, 80% of the area is covered by forests, and 67% are mountainous terrain. Located 586 kilometers south of Bangkok, the province is comprised of five districts namely, Muang Ranong, La-un, Kra-Buri, Ka-Pur and Suk Samran Districts.

Referring the data from Ranong Priovincial Health Office, Ranong, with the total population of about 177,224, has about 100,000 migrant workers, of which 61,895 are registered and the rest are working illegally (unregistered). Many of the migrants are working as fishermen, fishery-related workers, factories and construction workers, agriculture/ rubber planatation/ livestock workers but some as sex workers, general labors and domestic helpers (housemaids) (Ranong Provincial Health Office, 2005). Among the five districts of Ranong Province, Muang District holds about

80,000 migrant workers (80% of all the migrants in the whole province), of which 48,974 (61%) are registered as of June 2005, and up to 99% are Myanmar people with low socio-economic background. The number of registered workers decreased to about 15,000 and unregistered workers with three-month temporary stay increased up to 65,000 resulting in the same total number of migrant population with significant decrease in the percentage of registered workers to 25% (Muang District Health Office, 2007).

There are many legal and labor right issues in government sectors, private sectors, NGOs, resulting in difficulties for migrants to get access to health information and health care services (Ranong Provincial Health Office, 2005).

1.3 Research Questions

- What are the health seeking behaviours among Myanmar migrant workers in Ranong Province?
- What are the factors related to the health seeking behaviours for the perceived major health problems among Myanmar migrant workers in Ranong Province?

1.4 Research Objectives

Overall Objective

- To find out the health seeking behaviours and factors related to those behaviours among Myanmar migrant workers in Ranong province, Thailand.

Specific Objectives

- To describe the individual characteristics including living and working conditions
- To describe accessibility to healthcare services
- To describe the health seeking behaviours for perceived minor and major health problems and
- To determine the relationship between (1) individual characteristics,

  (2) accessibility to health care services and health seeking behaviours for the perceived major health problems of the migrants

1.5 Conceptual Framework

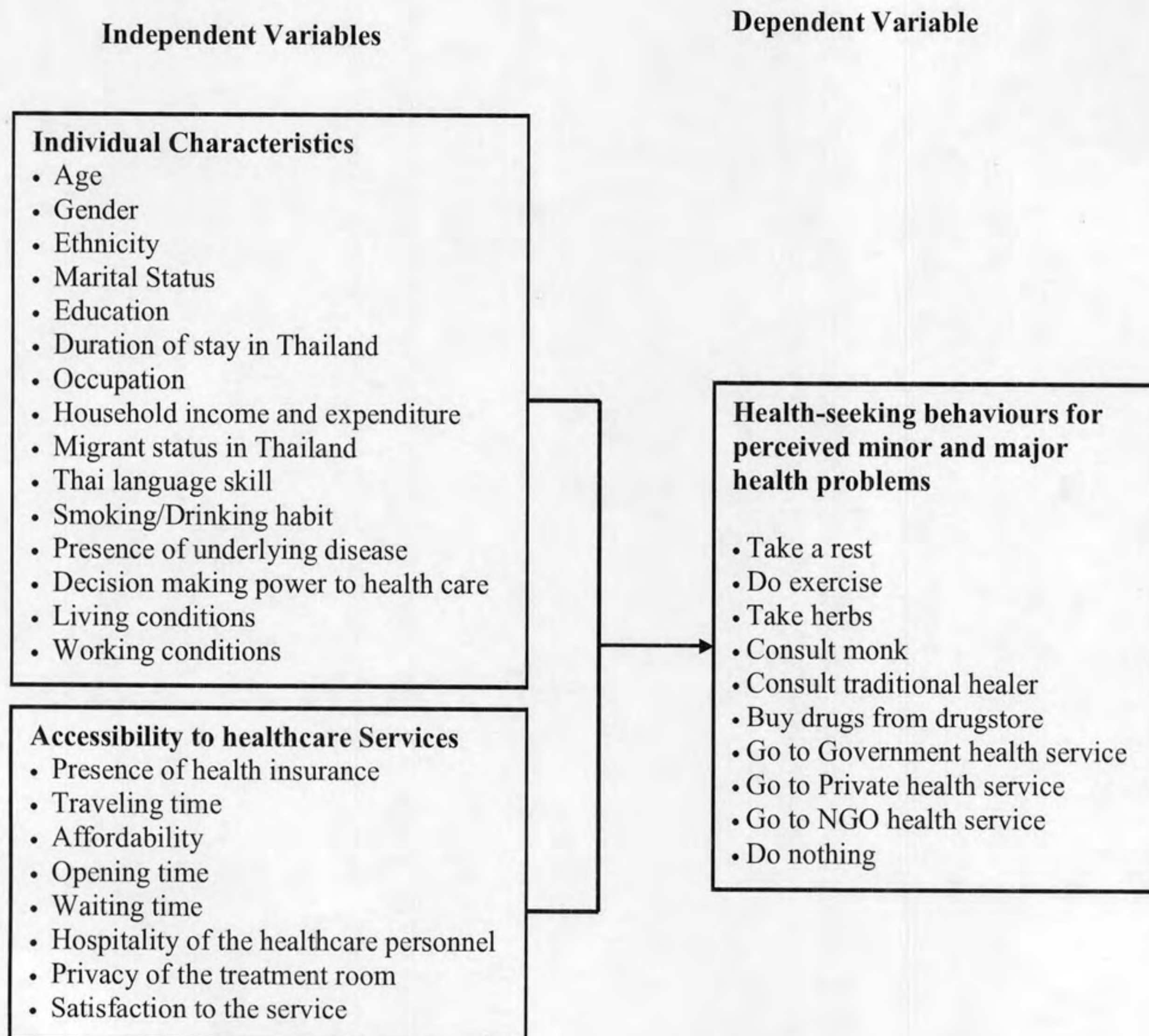

Figure 1 Conceptual Framework

1.6 Operational Definitions

Health seeking behaviour in this study refers to the actions people take in order to return to his/her health. The actions are organized into 10 groups namely (1)Taking a rest, (2) Do exercise, (3) Take herbs , (4) Consult monk, (5) Consult traditional healer (6) Buy a drug/drugs from drugstore, (7) Go to Government health service , (8) Go to Private health service, (9) Go to NGO health services and (10) Do nothing/ignoring.

Individual characteristics include age, gender, ethnicity, marital Status, education, duration of stay in Thailand, occupation, household income and expenditure, migrant status in Thailand, Thai language skill, smoking and drinking habits, decision making power to health care, living and working conditions. Living and working conditions in this study refers to place of resident, number of people staying together in a house, number of rooms inside the house, number of doors and windows in the house, type of latrine, working hours, working days, overall satisfaction to sound, ventilation/dust, light and smell condition of the workplace.

Accessibility to healthcare Services is defined by WHO into 4 aspects namely geographical accessibility, financial accessibility, cultural accessibility and functional accessibility (WHO, 1978). In this study, accessibility to healthcare services refers to the ability of using the healthcare services in terms of presence of health insurance, traveling time, affordability, opening time, waiting time at the health center, hospitality of the healthcare personnel, privacy of the treatment room and satisfaction to service. As there are many drugstores in Ranong that do not have pharmacist, they are not regarded as healthcare services.