Use of Health Line Consultations among Myanmar Migrants, Thailand: A Descriptive Study [1/]

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Abstract

This study was conducted to examine uses of health line consultations among Myanmar migrants in Thailand. Data were collected by phone interviews with semi-structured data compilation forms from 15:00 to 22:00 hours daily during the period from July 2009 to May 2010. Age, sex, address, date and time of call, sources of information, health concern, health advice, and missed calls were recorded. Descriptive statistics and content analysis were applied. It was found that 208 Myanmar migrants would have liked to consult the health line, but only 132 Myanmar migrants were able to use it. Twenty-eight cases consulted it for family planning and reproductive health, ten cases were with musculoskeletal issues, four cases with dental problems, seven cases each for upper respiratory and urinary tract infections, sixteen cases with gastrointestinal issues, six cases with skin issues, nineteen cases with infectious diseases, four cases with cardiovascular conditions, ten cases with general debility, four cases with surgical conditions, and one case related to an eye problem. It was concluded that effective health line advertisements coinciding with health line consultations should be carried out to increase awareness and usage of said consultations.

Keywords: *Phone interview, reproductive health, general debility, cardiovascular disease, musculoskeletal condition, upper respiratory and urinary tract infections.*

1. Background

In recent years, the movement of people across national boundaries has increased sharply. Thailand's geographic location in Southeast Asia, much higher income level, higher economic growth rate, and more favorable social and political climate attracted people from Myanmar, Lao PDR and Cambodia, to cross the border looking for job.

It is estimated that more than two million migrant workers are working and contributing to Thailand's economy **(**United Nations Country Team in Thailand 2005; Revenga 2006).

In Thailand, where majority of Myanmar migrants are residing, about 75% of registered migrants are from Myanmar (Ministry of Labor and Social Welfare 2005; PHAMIT 2011). They are hired in numerous industries and households. Registered migrants are concentrated in agriculture, construction, fishing and fish processing, and domestic work (Jinsong 2007).

In 2007, the Myanmar Ministry of Labor confirmed that the Myanmar workers who were illegally working in Thailand numbered about 500,000 working in the agriculture sector, factories, and industrial sectors (Jinsong 2007). About 91,000 workers were in Bangkok; about 144,000 in the middle areas of Thailand; 25,000 in the Eastern area; about 39,000 in the Western areas; 109,000 in Northern areas; about 41,000 in the Army District; about 42,000 in Chiang Mai; and about 12,000 in Chiang Rai (Kaekprayoon 2003; Jinsong 2007; Ministry of Public Health 2007).

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The prevalence of a large number of migrants in Thailand, most of which are undocumented, has caused several social consequences including health care problems and limited access to utilization of health services (Isarabhakdi 2004). Registered migrants in Thailand are eligible for health insurance, and can have access to health services under the 30 Baht health insurance scheme. Unregistered migrants, who form a much larger group, are not entitled to health insurance, and must make full payments for any health treatment. Moreover, hospitals are required to report health services to migrants to authorities. This discourages illegal migrants to use health services from hospitals. They instead buy medicines from drug stores. Lack of health awareness and access to prevention services and health care give rise to significant health problems (Jinsong 2007).

Only a small number of workers would go with employers to private clinics or public hospitals. Some are sent to a hospital by their friends in the event of sudden accidents or serious illness and the rest do nothing. Migrant workers in Mae Sot and Mae Hong Son tend to go to clinics opened by non-governmental organizations (NGOs) (Jinsong 2007).

A study on health and mortality differentials among Myanmar, Laos and Cambodian migrants in Thailand, using data from annual epidemiological reports during 1998-2006 and vital registration statistics during 2004-2008, shows that major causes of sickness of these migrants are acute diarrhea, malaria, and pyrexia with unknown origin. Major causes of death among Myanmar migrants are malaria, pneumonia, tuberculosis, leptospirosis and suicide (Srivirojana and Punpuing 2009).

More research is needed in order to reduce the health problems and to improve the health knowledge as little is known about the information needs or actual search behavior of people who use the medical consultations for health information. This descriptive study was conducted to examine uses of health line consultations, related health problems and obstacles encountered among Myanmar migrants in Thailand during health line consultations.

2. Objectives

The objectives of the study are as follows:

- To estimate the prevalence of using health line consultations among Myanmar migrants in Thailand.
- To describe the general characteristics of Myanmar migrants in Thailand.
- To find out the related health problems encountered among Myanmar migrants in Thailand during health line consultations.
- To find out the sources of information related to the use of health line consultations.

3. Methods

3.1 Study Design

The design of the study was based on a descriptive study with a qualitative approach.

3.2 Study Population

The sampling population comprised of Myanmar migrants residing in Thailand.

3.3 Period

Medical consultation was provided through a health line from 15:00 to 22:00 hours every day during the period from July 2009 to May 2010.

3.4 Study Tools

Data were obtained by phone interviews with semi-structured data compilation forms. The survey asked about age, sex, address, date and time of phone call, source of information, health concern. Date and time of missed calls were also recorded. The search was supplemented with citation search, reference list and by consulting experts. Study quality was assessed using a predetermined checklist and data were extracted independently onto a standard form.

3.5 Statistical Analysis

Descriptive statistics was used and data were analyzed by content analysis.

3.6 Inclusion Criteria

Studies that examined health seeking behavior among Myanmar migrants were included. Also, papers that reported qualitative research only, as well as research using qualitative and quantitative methods that reported qualitative findings were included. Both published and unpublished studies reported in English were considered.

4. Results and Discussion

Migrants in Thailand predominantly come from the neighboring countries of Myanmar (Burma), Cambodia and Lao People's Democratic Republic (PDR), and fill the low-paying "three D" jobs (dirty, dangerous and degrading). Limited economic opportunities in their home countries and high rates of poverty act as push factors that drive many young or able-bodied men and women to cross into Thailand to make money to support their families or to build their future. Pull factors include numerous job opportunities for migrants in Thailand, primarily in sectors that Thais have abandoned, such as fishing, construction, factories, domestic work and agriculture (PHAMIT 2011).

In source communities, migration has been fueled by the perception that working abroad is a mechanism for improving a family's financial well by being through visible displays of wealth, such as new houses, televisions or motorcycles - much of which has been purchased with remittances from Thailand. Migrants who return to their home communities have also perpetuated migration by taking new recruits back with them. Unfortunately, in many cases, migrants have also returned home with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), and many of these source communities are now disproportionately suffering from high rates of HIV compared to other parts of their country (Press 2005; PHAMIT 2011).

The recorded health problems among Myanmar migrants are listed in Table 1. The highest percentage (21.21%) is for family planning and reproductive health diseases. The second highest percentage (14.39%) is for infectious diseases. Gastrointestinal problems are in third place (12.12%). Musculoskeletal conditions and general debility are in fourth place (7.58% each). Respiratory problems and urinary symptoms are in fifth place (5.30% each). The other remaining problems are related to surgery, injury, cardiovascular conditions, skin issues, dental problems, eye problems and general issues.

Table 1. Health concerns of the respondents.

	Health concerns	No. of cases	Percentage
1	Family planning and reproductive health	28	21.21
2	Infectious diseases	19	14.39
3	Gastrointestinal	16	12.12
4	Musculoskeletal	10	7.58
5	General debility (weakness)	10	7.58
6	Urinary	7	5.30
7	Respiratory	7	5.30
8	Skin	6	4.55
9	Cardiovascular	4	3.03
10	Surgery cases and injuries	4	3.03
11	Dental	4	3.03
12	Eye	1	0.76
13	Other (General issues)	16	12.12
Total		132	100

In this study, one respondent complained of injecting oils into penis. This was consistent with the previous reports. Some migrant fishermen, especially from Myanmar, have enhanced their penises by injecting hair oil or inserting glass beads under the foreskin, something that is done on boats as a bonding ritual, and under the misconception that it gives women pleasure. These practices may considerably increase the risk of HIV transmission among fishermen and their partners, as penile implants make condoms fit improperly or break, cause abrasions in the

vaginal walls of their partners, and may lead to infections in the penis (PHAMIT 2011).

Structural barriers, such as language differences, the location of services, documentation, and concerns of arrest or harassment hamper migrants' ability to access proper reproductive and general health services, including condoms, and contribute to migrants' HIV/AIDS vulnerability and unplanned pregnancies which result in unsafe abortions and other reproductive health problems (PHAMIT 2011).

Limited access to condoms greatly contributes to inconsistent or low rates of condom use among migrants. When migrants are confined to their work areas or in remote communities, it makes it difficult to access condoms unless they are provided by the employer or a health office, which is rare. Currently, Public Health offices do not count migrants when procuring or distributing condoms, with the exception of sex workers. Thus, except for the efforts of NGOs in localized areas, migrants generally have low access to condoms (PHAMIT 2011).

Numerous barriers limit migrant's access to health services, and increase migrant's vulnerability to HIV/AIDS and reproductive health problems. Some of the most prominent barriers to accessing health services include:

- Language barriers may frustrate proper treatment (explaining symptoms or receiving instructions on treatment).
- Health insurance regulations, such as the requirement of going to "assigned health providers," may not be explained to migrants or may be confusing.
- Assigned health service providers (to obtain flat fee of 30 Baht) may be inconvenient to reach or far away, adding the expense and arrangement of transportation.
- Time of service provision by health providers may conflict with working hours of migrants.
- Many employers keep migrants' ID cards as a form of "insurance," restricting migrants' mobility and making them reliant on their employers to receive the benefits of the health insurance they have paid for.
- Fear of arrest or harassment deters some migrants, especially those who are undocumented.
- Negative attitudes of health providers towards migrants make migrants reluctant to seek treatment from public service providers.

Facing these barriers, migrants often resort to traditional remedies, which may result in delayed treatment for conditions such as malaria or tuberculosis (TB), or they may seek out traditional healers, some of who may have unsafe practices. Migrants also go to private clinics, which are convenient but expensive, or to NGO clinics, which, although are inexpensive and convenient, are few and far between (PHAMIT 2011).

Due to barriers in accessing public health services, migrants are generally unable to seek proper testing and treatment of sexually transmitted infections (STIs). Similarly, it is difficult for migrant women to pursue effective courses of contraception, resulting in high rates of unplanned pregnancy and related reproductive health problems, including unsafe abortion. Access to a standard set of health services is limited, making it that much more difficult to obtain specialized services such as VCT (voluntary counseling and testing). Even when migrants do access counseling services, ART (Anti-Retro-Viral Treatment) is currently unavailable at subsidized rates, placing treatment out of reach for migrants (PHAMIT 2011).

Migrants have communities of varying sizes in Thailand. Usually these communities are near or in work sites, such as in port areas, near factories or on construction sites. In other cases, they may be hidden in remote or undesirable locations to avoid attention. Many communities are exposed to swamps or marshy land, industrial effluent, or excessive amounts of trash. These conditions make migrants more vulnerable to outbreaks of mosquito-borne diseases such as dengue fever. Housing is often over-crowded, making migrants highly susceptible to other contagious diseases, especially tuberculosis, while in other cases

housing consist of ramshackle shanties, leaving migrants exposed to the elements. Access to clean water is also problematic with the worst conditions being at construction sites and in agriculture, where bathing water is often contaminated with runoff or pesticides (PHAMIT 2011).

Children of all ages are present in many migrant communities (in 2004 there were 93,082 registered migrants under age 15). Migrant children often receive preventative health only though vaccination campaigns, or mobile clinics. When migrant children become adolescents yet are unable to complete their education, they are more likely to enter the work force at a young age, leaving them vulnerable to the related health problems, including unplanned pregnancy and HIV/AIDS (PHAMIT 2011).

Undocumented migrants cannot legally access health care. Unregistered patients without money may be treated free for common complaints. Hospitals also subsidize more specialized treatment but approach the employer for a further contribution.

In practice, Burmese migrants rarely access even basic preventative health services such as vaccination. Very few married women we have met use any form of contraception, even if they do not want to become pregnant. Deliveries are at home, in poor conditions, often under the supervision of a traditional birth attendant. Constraints to access adequate health care are: being unable to speak and read Thai; not knowing what health services are available; having fears about security; and having no money for transport costs (Wilson 2005).

The age of the respondents who contacted the health consultation line is shown in Table 2. The 20-29-year age group has the maximum number of respondents (50%) The respondents of the 30-39-year age group are in second place (37.9%). A small number of young people less than 20 years old (2.42%) and elderly people over 50 years old (1.61%) form a minority group in calling for health consultation. Since all the respondents are migrant people and have to struggle for their living and survival, almost all of them must be in the working age group. As a matter of fact, this study shows that most people who called for health advices were from the 20-29-year and 30-39-year age groups.

Table 2. Age of the respondents.

	Age group (years)	No. of Cases	Percentage
1	<20	3	2.42
2	20 – 29	62	50.00
3	30 – 39	47	37.90
4	40 – 49	10	8.07
5	> 50	2	1.61

Table 3 shows that male respondents (55.30%) were more interested in asking for health advices than females (44.70%).

Table 3. Sex of the respondents.

	Sex	No. of Cases	Percentage
1	Male	73	55.30
2	Female	59	44.70

This result is consistent with the findings from the Office of Foreign Workers Administration, Department of Employment, Ministry of Labor, in June 2004 (PHAMIT 2011) as shown in Table 4, where the number of male Myanmar migrants older than 15 years (54.73%) was greater than the number of female Myanmar migrants of same age (45.27%).

Table 4. General registration of Myanmar migrants by age and sex (PHAMIT 2011).

Age	Male	Female	Total
0-11	33,271	29,883	63,154
12-14	7,277	6,597	13,874
>14	462,210	382,254	844,464

Source: Office of Foreign Workers Administration, Department of Employment, Ministry of Labor, 2004.

Statistical information about the career of the respondents is shown in Table 5. Most respondents are factory workers (25.62%). The second most prevalent job among people who wanted a consultation is as housemaid (23.14%). General workers are in third place (12.40%). The other jobs taken by Myanmar

migrants are in construction, selling, and tailoring industries (7.44% each).

In June 2005, the Office of Foreign Workers Administration, Department of Employment, Ministry of Labor, showed that Myanmar migrants Registered for Work Permit by Occupation have employment in the following areas: 1st - agriculture; 2nd - construction; 3rd - household workers; 4th - seafood processing and related industries; 5th - ocean fishermen; 6th - rice milling, brick factory, ice factory, goods transport, mining, fresh water fishing; 7th - animal husbandry; and 8th - others, like general laborer, service industry (PHAMIT 2011).

Table 5. Career of the respondents.

	Career	No. of cases	Percentage
1	Factory worker	31	25.62
2	Housemaid	28	23.14
3	General worker	15	12.40
4	Construction worker	9	7.44
5	Vendor (seller)	9	7.44
6	Tailor	9	7.44
7	Others	20	16.52

Occupations filled by migrants that have the highest risk behaviors include fishermen and sex workers. After being on a boat for long periods without sexual release, it is common for fishermen to band together, get drunk and visit sex workers during shore leave. Although drunkenness influences inconsistent or improper use of condoms, negative attitudes towards condoms, which are reinforced by uninformed beliefs about HIV/AIDS, play a greater role in inconsistent or low rates of condom use among migrant men. Negative attitudes and misinformation about HIV/AIDS are common among all migrants; however, they seem especially prominent among fishermen, including feelings that condoms are uncomfortable and unnatural.

The location of the respondents is shown in Table 6. Most of the respondents are residing around Bangkok (69.5%). Migrants residing in Samut Sakhon (Maha Chai) and Samut Prakan are in second place (5.08% each). Migrants residing in Pathum Thani are in third place (4.24%) followed by migrants residing in Nonthaburi and Mae Sot (2.54% each). It should be noted that along Thailand's western border, most specifically in Mae Sot in Tak Province, there is a concentration of factories.

Table 6. Location of the respondents.

	Living area	No	Percentage
1	Around and at Bangkok	82	69.5
2	Samut Sakhon (Maha Chai)	6	5.08
3	Samut Prakan	6	5.08
4	Pathum Thani	5	4.24
5	Nonthaburi	3	2.54
6	Tak (Mae Sot)	3	2.54
7	Others	13	11.02

For tax benefits, Karen and Burmese groups have a strong presence, working in factories (mostly in the garment industry), agriculture, construction, and as general laborers.

Shan, Lahu, Lisu, Karen, Burmese, Kachin and Ahkka ethnic groups from Myanmar are mainly found in the northern provinces in Thailand, most prominently in Chiang Mai. The variety of ethnicities in this province is as varied as the work that they do: agriculture and animal husbandry, construction, daily labor, factories of all sizes ranging from mass production to handicrafts, domestic work, small shops and restaurants, selling flowers, as well as being prominent in sex work.

The Mon group is becoming prominent along the southern half of the border with Thailand starting at Kanchanaburi. The migrants of the Mon group are working as fishermen in most central and southern coastal provinces and are prominent in the seafood processing industry in Maha Chai in Samut Sakhon Province.

There is a strong presence of Tavoy (Dawei) in the south, working in fishing, agriculture, and construction. In coastal areas along the northwestern corner of the Gulf of Thailand, there are pockets of Burmese, Karen and Arakanese (Rakhine), primarily working in the seafood industry and other marine-related industries.

Various groups from Myanmar are also found working in different capacities throughout Bangkok with numerous young women working as domestic laborers. Most registered migrants are residing in/around Bangkok, Tak, Chiang Mai, Ranong, Samut Sakhon, Samut Prakan and Chon Buri (Wilson 2005).

The health line medical consultation was carried out daily from 3 pm to 10 pm. Table 7 depicts that the total number of phone calls was 208. Among these, 63.46% (132 calls) were received calls and the rest 36.54% (76 calls) were missed calls.

Table 7. Phone calls.

Received call		Missed call	
Number	Percentage	Number	Percentage
132	63.46	76	36.54

Total number of calls = 208

The time distribution of received calls is shown in Table 8. For the total number of 132 received calls, two-thirds of the calls (66.67%) were received from 6 pm to 10 pm. The remaining calls (33.33%) were received from 3 pm to 6 pm. This may be due to the working hours of the respondents. Usually, they are expected to finish work around 6 pm. Hence, the respondents were more likely to give a call for medical consultation after finishing their work.

Table 8. Time distribution of received calls.

(3 pm - 6 pm)		(6 pm - 10 pm)	
Number	Percentage	Number	Percentage
44	33.33	88	66.67

The time distribution of missed calls is shown in Table 9. Most of the missed calls (64.47%) were made during the period from 10 pm on the same day to 3 pm on the next day. This means that most of the missed calls were made outside the consultation period since the duration of the medical consultation is only seven hours (from 3 pm to 10 pm every day). Probably, the calling migrants did not know the exact hours of the consultation period. This should serve as a reminder that advertisements for medical consultation should be enhanced and placed more broadly nationwide. Missed calls during the consultation period occurred because the researchers (phone operators) were also busy with other tasks or the migrants who made a call were probably impatient or busy in their workplace.

Table 9. Time distribution of missed calls.

3 pm - 10 pm		10 pm - 3 pm	
Number	Percentage	Number	Percentage
27	35.53	49	64.47

Table 10 shows that 25.44% of the Myanmar migrants got information about the medical consultation health line from radio advertisements. One-fourth of the migrants received information from friends (24.56%). Almost half (49.12%) of the migrant respondents obtained news from brochures and posters distributed at hospitals, clinics, restaurants and other public places.

Table 10. Sources of information for the migrants about the health line consultations.

	Source	Number	Percentage
1	Radio	29	25.44
2	Friends	28	24.56
3	Brochures	56	49.12
4	Other	1	0.88

5. Conclusion

Experience with health line consultations can provide useful guidance to increase the knowledge of health and improve health behaviors among migrants. This study also supports an increased access to sustainable, preventive and curative health care services of good quality for migrants. Continued interventions, such as administering effective health line advertisement programs, which coincide with health line consultations should be carried out to increase the awareness and subsequent health line usage among Myanmar migrants.

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