PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT BANGKOK METROPOLITAN AREA, THAILAND

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A Thesis Submitted in Partial Fulfillment of the Requirements
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การรับรู้และการใช้บริการการประกันสุขภาพภาคบังคับของแรงงานผู้ใหญ่ชาวพม่าในเขตบางขุนเทียน กรุงเทพมหานคร ประเทศไทย

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ฮนิน โอ มอน : การรับรู้และการใช้บริการการประกันสุขภาพภาคบังคับของแรงงานผู้ใหญ่ชาวพม่าในเขตบางขุนเทียน กรุงเทพมหานคร ประเทศไทย (PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICTBANGKOK METROPOLITAN AREA, THAILAND) อ .ที่ ป รึ ก ษ า วิทยานิพนธ์หลัก: ปีเตอร์ ซีนอล, 77 หน้า.

กระทรวงสาธารณสุข ประเทศไทยได้ดำเนินโครงการประกันสุขภาพแรงงานต่างด้าว (CMHI) สำหรับแรงงานต่างด้าวที่จดทะเบียนตั้งแต่ปีพ.ศ.2540 การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อการศึกษาถึงการรับรู้และการใช้บัตรประกันสุขภาพแรงงานในกลุ่มแรงงานต่างด้าววัยผู้ใหญ่ชาวพม่า ในเขตบางขุนเทียน เขตกรุงเทพมหานคร ประเทศไทย การศึกษาเชิงพรรณนาครั้งนี้เก็บข้อมมูลทั้งเชิงปริมาณและเชิงคุณภาพ ในช่วงเดือนพฤษภาคม-มิถุนายน 2558 จากกลุ่มตัวอย่างแรงงานชาวพม่า 400 ราย ทั้งที่ไม่ได้จดทะเบียนและจดทะเบียนในเขตบางขุนเทียน โดยใช้แบบสอบถามที่มีโครงสร้าง สำหรับการเก็บข้อมูลเชิงปริมาณ สำหรับข้อมูลเชิงคุณภาพใช้แนวสัมภาษณ์ในเชิงลึก การวิเคราะห์ข้อมูลเชิงปริมาณใช้โปรแกรม SPSS ปัจจัยทางสังคมและประชากรอธิบายด้วย ความถี่ ร้อยละ การหาความสัมพันธ์ระหว่างสภาพการทำงาน การเจ็บป่วย และการเข้าถึงบริการสุขภาพ ใช้การทดสอบไคสแควร์ในการวิเคราะห์ความสัมพันธ์ทางสถิติอย่างมีนัยสำคัญทางสถิติที่ p-value = 0.05 ผลการศึกษา พบว่าจาก กลุ่มตัวอย่าง 319 ราย มีการลงทะเบียนโครงการประกันสุขภาพแรงงานต่างด้าว ร้อยละ 43.5 เป็นเจ้าของบัตรประกันสุขภาพฯ และร้อยละ 36.2 (145 ราย) ใช้บัตรประกันสุขภาพฯ พบว่าการเข้าถึงบริการสุขภาพ อันได้แก่ เคยไปใช้บริการที่โรงพยาบาล การมีล่ามชาวพม่า ความพึงพอใจต่อการให้บริการสุขภาพมีความสัมพันธ์อย่างมีนัยสำคัญกับการใช้บัตรประกันสุขภาพฯ ความสัมพันธ์อย่างมีนัยสำคัญทางสถิติ ต่อการใช้ประกันสุขภาพฯ (p-value <0.001) และ การเจ็บป่วยในช่วง 6 เดือนที่ผ่านมา (p-value 0.05) หากแต่ปัจจัยทางสังคมและประชากร การจดทะเบียนบัตรประกันสุขภาพแรงงานต่างด้าว ระยะเวลาการทำงานอาชีพปัจจุบัน และคะแนนการรับรู้ไม่มีความสัมพันธ์ต่อการใช้บัตรประกันสุขภาพ

ผลการศึกษาสรุปได้ว่า การเคยไปใช้บริการที่โรงพยาบาล การมีล่ามชาวพม่า ความพึงพอใจต่อการให้บริการ และการเจ็บป่วยในช่วง 6 เดือนที่ผ่านมา มีความสัมพันธ์ต่อการใช้ประกันสุขภาพฯ ดังนั้นการส่งเสริมความตระหนักในเรื่องการมี และใช้บัตรประกันสุขภาพแรงงานในกลุ่มแรงงานต่างด้าวเป็นเรื่องจำเป็น

คำสำคัญ: การรับรู้, การประกันสุขภาพ แรงงานพม่า

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต .....

ปีการศึกษา 2557 ลายมือชื่อ อ.ที่ปรึกษาหลัก .....

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HNIN OO MON: PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICTBANGKOK METROPOLITAN AREA, THAILAND. ADVISOR: PETER XENOS, Ph.D., 77 pp.

Background: The Ministry of Public Health (MOPH), Thailand has been implementing the Compulsory Migrant Health Insurance Scheme (CMHI) for registered migrant workers since 1997. This study objective is to study the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand.

Method: This is a cross-sectional descriptive study with both quantitative and qualitative methods (Mixed-method). Data collection was done during May-June 2015 to 400 Myanmar migrant workers registered and unregistered in Bang Khun Thian. Structured questionnaire for quantitative and in-depth interview for quantitative data were carried out. Quantitative data were organized and analyzed by the researcher using SPSS for quantitative study. Frequency, percentage are used for socio-demographic variables, working condition, medical disease, and accessibility to health care services. We use Chi-square test to analyze the statistical relationship with statistical significance p-value = 0.05 together with analysis of qualitative data.

Results: Out of 319 respondents who had registration status, 43.5% own CMHI card. Among the respondents who owned CMHI card, 145 respondents use the card which is 36.2%. The accessibility variables such as been to hospital, translation services and general satisfaction towards health services and usage of CMHI card are highly associated significantly with p-value <0.001. Having an illness during last 6 months is associated significantly with usage of CMHI with p-value less than 0.05. There was no significant association between sociodemographic characteristics and usage of CMHI card. Registration status and duration in current job are not associated with usage of CMHI card. There is no relationship between perception scores and the usage of CMHI card.

Conclusions: The usage of CMHI card is associated with having an illness, been to the hospital, translator assistance and satisfaction towards health services from hospital.

Recommendation: raising awareness on compulsory migrant health insurance scheme should be done together with promotion on usage and ownership of CMHI card.

Field of Study: Public Health Student's Signature .....

Academic Year: 2014 Advisor's Signature .....

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CONTENTS

Page

LIST OF TABLES

LIST OF FIGURE

LIST OF ABBREVIATIONS

HIV	Human immunodeficiency virus
CMHI	Compulsory migrant health insurance
WHO	World Health Organization
MOPH	Ministry of Public Health
IOM	International organization of migration
NGO	Non-government organization
UC	Universal coverage
PDR	People's Democratic Republic

CHAPTER I
INTRODUCTION

1.1 Background and Rationale

Migration in Thailand

Thailand is a major destination country for an international migration especially for migrants from neighboring countries, namely Cambodia, Lao PDR and Myanmar. Migrants in Thailand can be classified in 2 groups such as regular migrants and irregular migrants. Migrants come into Thailand with several purposes including traveling, seeking for an employment opportunity and fleeing from the unrest in their homeland. (Tangcharoensathien et al., 2010)

At the end of December 2012, the statistical data provided by the National Statistical Office stated that there were around 1.133 million migrant workers in Thailand. There were around 940,531 regular migrant workers and around 193,320 irregular migrant workers. However, many scholars pointed that there is an estimation of 3 million migrant workers influx into Thailand both legally and illegally. The migrant workers from the three neighboring countries account for 87.73 percent over overall migrant workers in Thailand. (Meepien & Sangkaew, 2013)

During 1980s until late 1990s, the international migration in Thailand is the consequent of the economic reason and the political unrest. However, the international migration since 1997 is mainly the consequent of the economic reason because there is the shortage of low skill workers in Thailand; therefore Thailand needs to import migrant workers from the neighboring countries. (Khan, 2005)

Cross border migration between Myanmar and Thailand

The Thai-Myanmar border is approximately 2,800 kilometers long with nine Thai provinces located next to Myanmar, known as Chiangmai, Chiangrai, Maehongson, Tak, Ratchaburi, Kanchanaburi, Chumporn, Prachuabkirikhan, and Ranong. Although there are only six official border-crossing points, there are numerous points that the government cannot control because those areas are widely distributed among mountain areas and forests. (Meepien & Sangkaew, 2013)

Most of the migrants who stay for long time had been issued work permits, or residency temporarily, and are permitted to work in areas under controlled. Migrants continued to flow in as political unrest in Myanmar intensified, large proportion of migrants represents displaced persons over the Thai-Myanmar border occurring during the 1980s and 1990s. According to Thai government policy, many of the migrants are identified as displaced persons, refugees who live in border camps, or unauthorized workers, particularly those who have moved out from border camps. (Isarabhakdi, 2004)

Political instability and minimal economic growth in neighboring countries influence irregular migrants' influx into Thailand. While there are more than 140,000 displaced persons from Myanmar living in temporary shelters along the Thai-Myanmar border, it is assumed that many more are living and working in Thailand outside of the shelters. They can be temporary residents either with registered or unregistered documents. The migrants living in shelters or refugee camps receive assistance from numerous non-governmental organizations (NGOs) which give them food, basic health services and education. This is not the case for unregistered migrants residing in other areas rather than shelters or camps who remain highly vulnerable and mostly not accessible to basic health care and education. Registered migrants can receive an annual check-up and health services through a Compulsory Migrant Health Insurance (CMHI) in case they bought CMHI card. (Tangcharoensathien et al., 2010) Bang Khun Thian is one of the 50 districts (Khet) of Bangkok, Thailand. Its neighbors, Neighboring districts are Bang Bon,Chom Thong and Thung Khru districts under Bangkok Metropolitan Area. Samut Prakan province as well as Samut Sakhon provinces is connected to Bang Khun Thian. Bang KhunThian is situated in southernmost part of Bangkok among other districts and it is connected to the sea.

Health condition and Health seeking behavior of migrant workers

Although access to primary health care is a basic human right, being stateless in remote areas excludes migrants from the relatively well established Thai public health system. Many migrants live in the same area or in close proximity to Thai communities, and improving health conditions among migrants will ultimately benefit and assist with maintaining the health security of host communities. While the Ministry of Public Health (MOPH) endorses the Healthy Thailand policy, and has clear

intentions to deliver basic health services to all, the actual provision of services remains a significant challenge.

Many migrants continue to have limited or no access to basic health care primarily due to: 1) their illegal status, poverty, and remoteness of their residence, all of which contribute to their marginalization; 2) limited knowledge and understanding about their rights to basic health care; 3) language and cultural barriers; 4) high levels of mobility amongst some migrant populations; 5) lack of cooperation from employers toward their employees; 6) negative perception and attitudes amongst health service providers; and 7) MOPH's limited financial and human resources to provide adequate health services to migrants.

Thailand health services for migrant workers (compulsory migrant health insurance scheme)

Public health system of Thailand launched of universal health care coverage in 2002. The development of the public health system and healthcare financing has contributed significantly to an equitable service provision and financial contribution of the health care system. But if a person is not a Thai nationality and is a stateless or displaced, they will not be included in Universal Health Coverage Scheme (UC). Before introducing UC policy, they were cover by the Low Income or Health Card Scheme.

The number of migrant workers from Myanmar, Lao PDR, and Cambodia coming to Thailand is proportionate to the demand for labor in Thailand. However, the number of migrant workers who are registered has been significantly declining since 2005 and therefore most of migrant workers who working currently in Thailand are not registered.

The Ministry of Public Health (MOPH) has been implementing the Compulsory Migrant Health Insurance Scheme (CMHI) for registered migrant workers since the cabinet resolution on 24 June 1997. The CMHI gives migrant workers and dependents access to essential health care services and mobilize budgets for public hospitals through CMHI card. (Srithamrongsawat & Wisessang, 2009)

The decline in the number of registered migrants has inevitably impacted on healthcare financing options for all migrant workers. Universal coverage plan in Thailand does not include for displaced persons and unregistered migrants. Normally,

an out-of pocket payment is required to access health care at public health facilities unless the migrants have CMHI health card. (Srithamrongsawat & Wisessang, 2009)

An unclear government policy towards the registration of migrant workers together with law enforcement's constraints has resulted in a decrease in the total number of registered migrant workers although many migrants still continue to come to work in Thailand. An increase in hospital exemptions and payments by out of pockets are affecting the sources of financing migrants' health.

CMHI revenue accounted for 79% of all financing sources for migrant workers in 2005, dropping to 60% in 2006. Hospital exemptions and out-of-pocket payments each accounted for 20% of healthcare financing for migrant workers, predominantly unregistered migrants in 2006. The more hospital exemptions are given, the higher the financial burden on hospitals. In border provinces with larger number of unregistered migrants and displaced persons are more affected by this than others. There is no additional government budget to subsidize exempt services to both Thai and non-Thai populations who cannot afford to pay. (Srithamrongsawat & Wisessang, 2009)

This study analyzes the perception and usage of compulsory migrant health insurance scheme among adult among Myanmar Migrant Workers in Bang Khun Thian district of Bangkok Metropolitan area, Thailand. It is expected that factors such as socio-demographic characteristics, medical conditions, working conditions and accessibility to health services and perception and usage of compulsory migrant health insurance will be related. It is also expected to give baseline data to make relevant decisions to improve the health care services for migrant workers in the future.

1.2 Research question

- What is the perception towards compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand?
- What is the rate of usage and ownership of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand?

- Is there any association between the socio-demographic characteristics, working conditions, medical condition, accessibility, and perception with the ownership as well as the usage of compulsory migrant health insurance scheme?

1.3 General Objective

- To study the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang KhunThian district, Bangkok Metropolitan area, Thailand

1.4 Specific Objectives

- To explore the perception and usage of compulsory migrant health insurance among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand
- To find out the association of the socio-demographic characteristics, working conditions , medical condition, accessibility, health information and perception with the usage of compulsory migrant health insurance scheme

1.5 Expected Benefit & Application

- This study is expected to give baseline data on perception and usage of Compulsory migrant health insurance Scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand
- It is expected that findings will be useful for the review and planning of better health care services system in the future

1.6 Conceptual framework

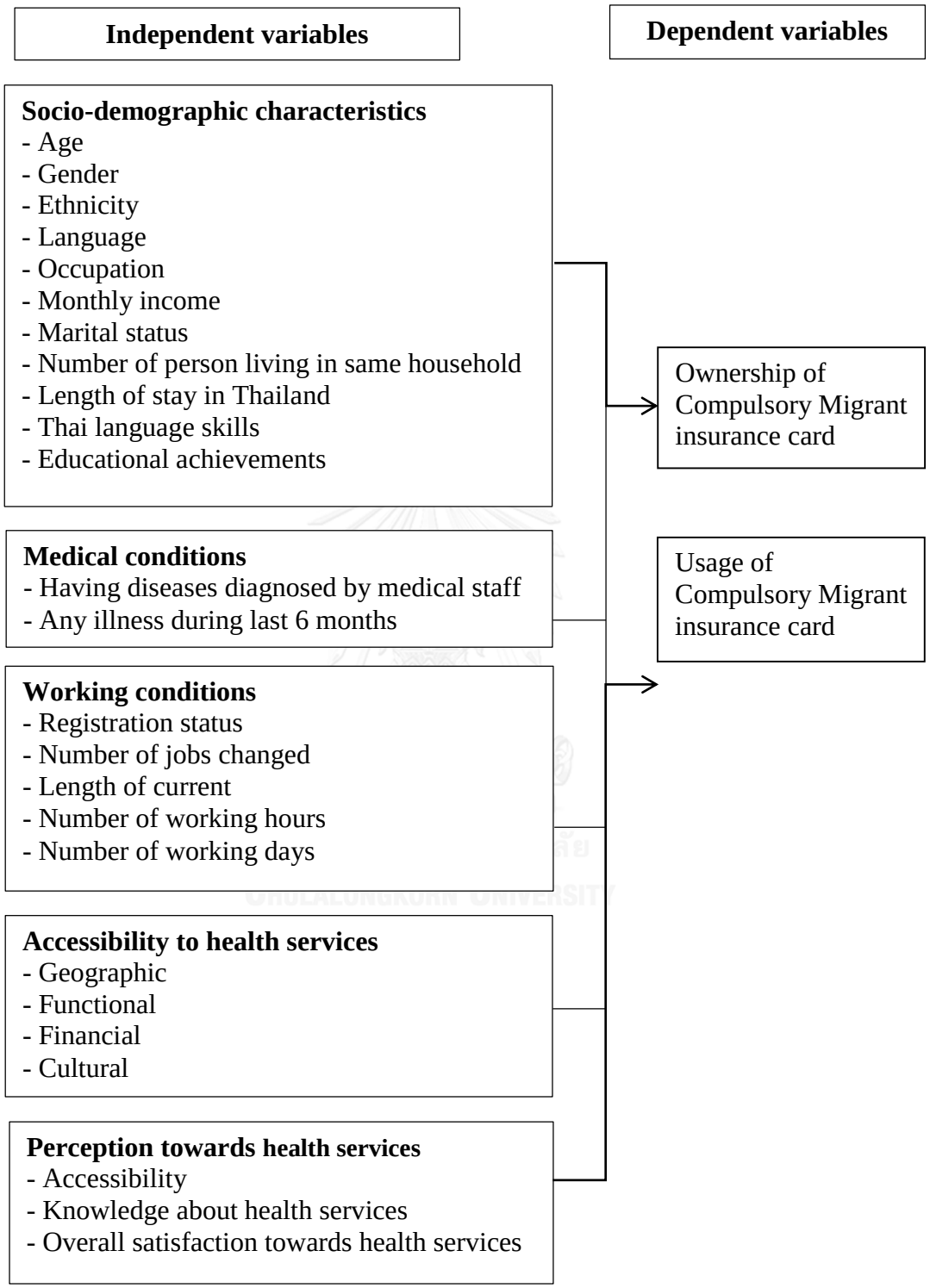

Figure 1 Conceptual framework

1.7 Operational Definitions

A migrant worker refers to a person who is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.

Independent variables

Sociodemographic characteristics

Age refers to how old the interviewee is at the time of the interview**.**

Gender refers to male and female.

Ethnicity refers to which ethnicity does the interviewee belongs to and it is diversified into Mon, Karen, Rakhine, Dawei, Burmese and others.

Marital status refers to the current marital status of the interviewee.

Occupation refers to the job of the interviewee: factory worker, construction worker or others

Monthly income refers to how much the interviewee earn monthly

Number of person living in the same household refers to the number of people living in the same household with interviewee

Length of stay in Thailand is the duration of interviewee staying in Thiland

Thai language skills refer to whether interviewee can communicate in Thai language or not

It will be classified into 4 types as cannot speak at all, can speak basically, can speak Thai language fluently but cannot read and write and Fluent in Thai language

Educational achievements refer to the highest year or education of the interviewee. It was divided into no education, primary education, secondary education, higher education.

Medical condition

Having diseases diagnosed by medical staff refers to whether interviewee has any diseases diagnosed by medical personal e.g. Diabetes, hypertension, TB, malaria, sexually transmitted diseases.

Any illness during last 6 months refers to whether interviewee has any illness during last 6 months

Working conditions

Registration status

Interviewee current migrant status is as registered or not

Number of jobs changed
How many jobs did the interviewee changed before working in current job in Thailand

Length of current job refers the period of working in the current working place

Number of working hours refers to the number of working hours per day that interviewee has to work

Number of working days refers to the number of days that interviewee has to work per week

Accessibility to health care services is defined into 4 aspects namely geographic accessibility, functional accessibility, financial accessibility, cultural accessibility.

In this study, accessibility to health care services refers to the ability of using health care services in terms of travelling time, presence of health insurance, health care information received from where and from who (friends, family, workplace, community, volunteers, social media), affordability, waiting time at the health center, language barrier and satisfaction to service.

Perception means the respondents' opinion of agree or disagree with the statement concerning the health care services towards migrant workers

Answers are categorized into five levels: strongly disagree, disagree, uncertain, agree and strongly agree. The answer "strongly disagree" got 1 score, "disagrees" got 2 scores, "uncertain" got 3 scores, 'agrees" got 4 scores, 'strongly agrees" got 5 scores

There will be 7 questions with minimum score 1 and maximum score 5, the possible score ranges from 7 – 35 and the respondents' perception is classified into three levels. The cut-off point for "high level perception" was greater than 80% of total scores, that for "moderate-level perception" was from 60 – 80% and for "low-level perception" was less than 60% of total scores.

Dependent variables

Own Compulsory Migrant Health Insurance refers to whether interviewee owns CMHI card or not.

Usage of Compulsory Migrant Health Insurance refers to whether interviewee uses CMHI or not.

CHAPTER II
LITERATURE REVIEW

2.1 Health insurance

Health insurance is the compensation of loss due to ill health. There are two types of health insurance such as voluntary health insurance and compulsory health insurance. The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. For a community or country to achieve universal health coverage, several factors must be in place, including: A strong, efficient, well-run health system that meets priority health needs through people-centered integrated care (including services for HIV, tuberculosis, malaria, non-communicable diseases, maternal and child health).

It also requires recognition of the critical role played by all sectors in assuring human health, including transport, education and urban planning. Universal health coverage has a direct impact on a population's health. Access to health services enables people to be more productive and active contributors to their families and communities. It also ensures that children can go to school and learn. At the same time, financial risk protection prevents people from being pushed into poverty when they have to pay for health services out of their own pockets. Universal health coverage is thus a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. Universal coverage is the hallmark of a government's commitment to improve the wellbeing of all its citizens. (WHO, 2013)

2.2 Compulsory Migrant Health Insurance (CMHI)

In the report "Financing healthcare for Migrants: A case study from Thailand" by Samrit Srithamrongsawat and Ratanaporn Wisessang stated that a health insurance program for migrant workers was first introduced in 1997, following a cabinet resolution which allows the MOPH to provide health insurance to migrant workers at no less than 500 Baht per person per year. In 2001, an additional cabinet resolution was passed which required that all registered migrant workers comply with annual health screening at a cost of 300 Baht and annual CMHI membership at a cost of 1,200 Baht. In addition, a co-payment of 30 Baht per visit is required when receiving care from

health facilities. In 2004, the price of annual screening and health insurance cards increased to 600 Baht and 1,300 Baht respectively. The CMHI scheme primarily targets migrant workers; however it only applies on a voluntary basis for their dependents. (Srithamrongsawat & Wisessang, 2009)

According to the report "Healthy Migrants, Healthy Thailand: A Migrant Health Program Model" by Nigoon Jitthai published by International organization of migration (IOM) and Ministry of Public Health, Thailand (MOPH), improvements in registered migrant workers have been demonstrated with the usage of health care under CMHI scheme. But the usage of outpatient care is still below universal coverage and Social security scheme. Migrants and displaced persons tend to do self-medication more than local Thai nationalities. Language barrier and culture difference can explain about lower rate of utilization even though many hospitals hire volunteers to assist with interpreter services. Limitation of human resource on translators will affect the assistance service received by migrants' workers during their visit to hospital. (Jitthai, 2009)

Compulsory migrant insurance scheme targeted for screening, treatment, promotion as well as prevention and surveillance of diseases.

CMHI Health screening includes the following;

- CXR (chest X-ray) with sputum examination to find out cases of TB
- Blood test for syphilis and microfilaria infections
- Urine test to check for narcotic drug use for men and to check for pregnancy in women
- CMHI also provide Diethylcarbamazine (300 mg DEC) and every six months for everyone who found microfilaria in blood test.
- Leprosy screening is also included and a single dose of Albendazole 400 mg is given to control parasite infections.

If the migrants have active TB, leprosy or filariasis, syphilis stage III and mental disorder, they cannot have work permit after health screening. Migrants who are drug addicts and alcoholics will not be allowed to get work permits as well.

Benefit package of CMHI includes examination, diagnosis and treatment of general illness, delivery charges with neonate medical care. It also includes dental care including tooth extraction, filling and scaling, medicine covered by the National Drug List. Benefit package stated for medical referral as in case designated hospital for migrant cannot provide suitable treatment, hospital can refer patient to another hospital within or outside of the registered province.

The conditions that are not included in Benefit package are mental illness, Rehab and treatment of narcotic drug addiction, road traffic accidents, infertility and IVF treatments, sex change (reassignment) surgery, plastic surgery without indication, medical treatment without indication, hospital stay > 180 days except due to complications. Research done with treatment, clinical trial cases that need treatment, dialysis, transplant (liver, renal, lung), dentures, ART (anti-retro viral therapy) for HIV infection or AIDS (except in case of PMCT- prevention of mother to child transmission) are not covered by CMHI. (Jitthai, 2009)

The MOPH reserves a portion of the budget, 50 Baht per person, to reimburse hospitals providing high cost care to migrant workers. The reserve is a mechanism to redistribute financial risks among MOPH hospitals, particularly for hospitals with small numbers of registered migrants. In addition, it ensures that migrant workers will have access to high cost services as required, and health care providers will be reimbursed for costs of service provision.

2.3 Accessibility to health services

Access to health care services is the process initiated from the need for the health care to contacting and using the health services. According to WHO definition, accessibility is the number or proportion of the given population that can be expected to use a specified facility, service, given a certain barrier to access, which may be physical (distance, travel, time), economic (travel cost, service fee, time cost) or social and cultural (language) barriers. (WHO, 2008)

(1) Geographical accessibility : it is the transportation, travel time, the physical distance from living place of people to the primary care facility

(2) Functional accessibility : it is the process and method of managing of care to those who need it,

(3) Financial accessibility: it is the payment for the use of services. Financial access also relates to time and money spent to reach health services.

(4) Cultural accessibility: it relates to the appropriateness of methods used with the cultural pattern of the community

There is association of migrant workers' using health service center, owning insurance, doctor fees and opening hours of health clinic significantly. (Aung, 2008)

Migrant registration status and duration of stay in an area are also associated with the choice for public hospital and private hospital. (Aung, 2008)

Health related quality of life (QOL) is associated with health service accessibility, perception towards health system and health services, having insurance card. (Thein, 2008)

2.4 Review of related studies

A study done in China regarding health insurance benefit for migrant workers showed that benefit package focused on urban population of migrants is more effective in promoting physical exams and improving health status for migrant workers and also significant benefits and increasing usage of preventive care. (Qin, Pan, & Liu, 2014)

The findings from a study about migrants in Austria and their utilization of healthcare services stated that migrants are a significant proportion of Austria population but information regarding mental health of migrants in Austria is limited. In this study showed that having a dysphoric disorder was associated with a higher utilization of healthcare services among migrants. (Kerkenaar, Maier, Kutalek, & Lagro-Janssen, 2013)

Therefore, a person with a disease will use and know more about health services or health insurance than a person without any disease or in health condition.

A study done in Europe showed that migrants cannot be considered as a homogeneous community and mental health is different among those groups. And

access to health care services by migrants is influenced by the legal regulations of the host country. (Lindert, Schouler-Ocak, Heinz, & Priebe, 2007)

Overall the study pointed out that language barrier is associated with less frequent hospital visit, less follow up, lesser understanding of doctors' recommendation, more ER visit, longer duration of hospital visit, dissatisfaction of health care services. Improvement in communication between patients and service providers will increase the usage and satisfaction towards health system. Migrants' access to health care services has to follow national rules. Migrants with unregistered documents are not allowed to use health system in some countries.

Philipa Mladovsky studied in a research that analyses the migrant health policies in Europe showed that lower usage of health system result in worse health and higher rate of avoidable death when compared to migrants and natives. This can also result in delaying primary care and more expensive emergency treatment cost. (Mladovsky, 2009)

A study about health insurance (OPD insurance product) in rural stated that owning an insurance card leads to more visit to health care workers and patient can receive early diagnosis and timely referrals to a hospital. Thereby patient will get treatment at the early stage of disease and can save cost. This study also found out that if the governments and insurance agencies can produce insurance scheme or benefit packages with outpatient care services, it will improve the utilization of insurance packages. India (Mahal, Krishnaswamy, & Ruchismita, 2013)

In a paper that studies the association between migrant workers' labor contract status and their social insurance usage in China showed that having a labor contract improved the migrant workers' utility for insurance. This study highlighted that a long-term labor contract and the migrant workers' ability to obtain social insurance coverage are associated positively and also influences security and protect basic rights. (Gao, Yang, & Li, 2012)

World health report 2010, health system financing stated that contributions necessary to be compulsory so that healthy and rich persons will need to pay as well and the funding for the poor and sick will be enough as well. Voluntary insurance

packages can raise some funds without much pre-payment as well as pooling. It will also help to promote benefits of insurance to the people. They have a limited ability to cover for people who cannot pay for premium due to poverty. (Tangcharoensathien et al., 2010)

Chantavanich et al, 2012 showed in the report about migration themes in ASEAN that the employer had to buy social security scheme (SSS) for the employee/migrant worker offered by the Social Security Office of the Ministry of Labour. Employers are responsible for informal sector migrant workers who cannot buy SSS, they should be entered into health insurance by Ministry of public health or other private insurance companies. (Chantavanich, Middleton, & Ito, 2012)

Tussnai Kantayaporn & Siwanart Mallik, 2013 stated in Migration and Health Service System in Thailand: Situation, Responses and Challenges in a Context of AEC in 2015 that Compulsory health insurance for Myanmar and other migrant workers in Thailand started in 1999 when Ministry of Public Health issued the "Measures and Guidelines for Health Exams and Insurance for Foreign Migrant Workers." (Kantayaporn & Mallik, 2013)

With these guidelines, Bangkok public hospitals work together with Bangkok Metropolitan Administration for responsibility of the services. One private hospital in Samut Sakorn and Bangkok also involved in this service provision.

During 2004 and 2011 health insurance program of migrant workers are reviewed by the Cabinet each year for re-authorization process. There is also extensive debate regarding whether health insurance should be provided only to migrants with registered status and not to the migrants with unregistered documents.

Another standpoint in these debates which is endorsed by many non-government organizations and human right activists are that insurance coverage should be expand to all migrants regardless of their legal status as health is basic human rights. (Kantayaporn & Mallik, 2013)

After literature review, there has been no previous study done for usage and perception of compulsory migrant health insurance scheme among Myanmar migrant

workers in Thailand in particular. This study is thus intended to fill this knowledge gap and attempt to investigate whether there is an association between the ownership and usage of CMHI with socio demographic factors, medical conditions, working condition and accessibility to health care services and perception towards CMHI in adult Myanmar migrant workers in Bang Khun Thian District, Bangkok, Thailand.

CHAPTER III
RESEARCH METHODOLOGY

3.1 Study Area

This study was done in Bang Khun Thian which is one of the fifty districts (Khet) of Bangkok, Thailand. Neighboring districts are Bang Bon, Chom Thong and Thung Khru districts under Bangkok province. Samut Prakan province as well as Samut Sakhon province is also connected to Bang Khun Thian. It is situated in southernmost part of Bangkok among other districts and it is connected to the sea.

3.2 Research Design

Researcher used mixed-method (both cross-sectional descriptive study for quantitative study and qualitative study methods) in this study.

As the quantitative research is numerical representation of the study and qualitative study is non-numerical representation and interpretation of the study. (Casebeer & Verhoef, 1997) In order to discover the underlying meanings and better understanding of the issue studied in quantitative survey, qualitative study is added for mixed method study. One of the reasons for adding qualitative study in addition is to complement the findings of quantitative study not to compete or ignore the findings from both surveys.

Cross-sectional descriptive study and qualitative study were used to assess the perception and usage of compulsory migrant health insurance scheme among adult Myanmar migrant workers in Bang Khun Thian district of Bangkok Metropolitan area, Thailand.

The results of the study are presented in 2 sections.

Section 1: Quantitative study of the results from questionnaires

Section 2: Qualitative presentation of the results from the in-depth interviews conducted with the sampling group after quantitative study

3.3 Study Population

The primary unit of the study were Myanmar migrant workers aged 18 years and above, male and female, registered and unregistered, from different backgrounds and ethnic group of Burmese, Karen, Mon, Rakhine, Shan, etc.

3.4 Sample size

3.4.1 Sample size for quantitative study

The sample size was calculated by following formula that was created by Daniel, (Daniel, 2005)

$$n = \frac{Z^2(p \times q)}{d^2}$$

n = sample size

Z = standard value for 95%

Confidence interval = 1.96

d = error allowance = 0.05

p = the proportion of the target population who uses compulsory migrant health insurance = 50% = 0.5 (with the assumption of the maximum variance)

q = 1- p = 0.5

$$n = \frac{Z^2(p \times q)}{d^2}$$

$$n = \frac{(1.96)^2(0.5 \times 0.5)}{(0.05)^2} = 384$$

Sample size = 384.

A total of 400 interviews were made to cover missing values and losing respondents.

3.4.2 Sample size for qualitative study

In this study, six participants were chosen purposively for deeper understanding of research problem according to the participant's willingness to give information regarding perception and usage of CMHI scheme. In-depth interview was done with six participants from quantitative data collection who can give information about CMHI scheme. We chose these six participants for qualitative data collection according to the different backgrounds of the respondents such as duration of stay in Thailand ranged from 2 years to 11 years, distribution of gender (3 Males and 3 Females), as well as for their experiences during accessing the health care services and usage of CMHI card.

We wanted to recruit more interviewees to perform more interviews but due to limited time of the research and rejection from other proposed participants, we can only interviewed six participants in this study.

3.5 Sampling Technique

Bang Khun Thien district is selected purposely among 50 districts of Bangkok province due to the density of Myanmar Migrant workers living in this area.

The number of migrants household living in Bang Khun Thien district was obtained from a Thai-NGO helping Bang Khun Thien migrants' community (P2H-Path2heath) and community based NGO (Network for migrant workers development-NMWD).

From this obtained list of migrants household, simple random sampling of the household of respondents was done by lottery method. Everyone living in the selected household will be interviewed using structured questionnaire.

All households of adult Myanmar migrant workers (age 18 and above) in the district had an equal opportunity to be selected.

Researcher contacted to community based NGO team prior to collection of data and conduction of survey.

3.5.1 Inclusion criteria

Myanmar migrant workers

- Age 18 years and above
- Who can speak Burmese Language though they are not Burmese ethnicity
- Who are willing to participate in the research
- male and female, registered and unregistered

3.5.2 Exclusion criteria

- Myanmar migrant workers who has difficulty in communicating in Burmese
- Who are temporary stay in Bang Khun Thien
- Who are working as volunteer at community based NGO team

For qualitative study, 6 participants were selected in order to do in-depth interviewing after quantitative data collection. The inclusion and exclusion criteria were the same as quantitative sampling. The participants from quantitative data collection

were chosen purposively due to their willingness to give information and for expression of perception and experiences during usage of CMHI card.

3.6 Measurement Tools

Data collection tool was structured questionnaire with face to face interviewed by researcher and team for quantitative study and in-depth interview by researcher for qualitative study. Opinions and guidance from experts was obtained to get content validity of research instrument. Dr.Peter Xenos from College of Public Health Sciences, Chulalongkorn University had already reviewed the questionnaire. Back translation of the questionnaire from English to Burmese and then Burmese to English by different experts was done as well.

In this study, there are both independent variables and dependent variables. Questionnaire was constructed by including

3.6.1 Independent variables

Socio-demographic characteristics

Age, gender, ethnicity, marital status, occupation, number of persons living in the same household, monthly income, length of stay in Thailand, Thai language skills, educational achievements

Working conditions which includes work permit, number of jobs changed, length of current job, number of working hours, number of working days

Medical conditions which includes interviewee has any diseases diagnosed by medical staff, any illness during last 6 months

Accessibility to health services namely geographic accessibility, functional accessibility, financial accessibility, cultural accessibility will be included.

Accessibility to health services refers to the ability of using health care services in terms of
travelling time, presence of health insurance, health care information received from where and from who (friends, family, workplace, community, volunteers, social media), affordability, waiting time at the health center, language barrier, satisfaction to service.

Perception means the respondents' opinion of agree or disagree with the statement concerning the health care services towards migrant workers

Answers are categorized into five levels: strongly disagree, disagree, uncertain, agree and strongly agree

The answer ‘strongly disagree’ got 1 score

The answer ‘disagree’ got 2 scores

The answer ‘uncertain’ got 3 scores

The answer ‘agree’ got 4 scores

The answer ‘strongly agree’ got 5 scores

There will be 7 questions with minimum score 1 and maximum score 5, the possible score ranges from 7 – 35 and the respondents’ perception is classified into three levels. The cut-off point for “high level perception” was greater than 80% of total scores, that for “moderate-level perception” was from 60 – 80% and for “low-level perception” was less than 60% of total scores.

3.6.2 Dependent variables are ownership of CMHI or not and usage of Compulsory Migrant Health Insurance.

For qualitative study: used in-depth interview with guided questions set shown in appendix H.

3.7 Pilot testing

Pilot testing of the questionnaire was conducted on 30 Myanmar migrant workers in Bang Bon district one month before doing an actual survey. The aim of the testing was to evaluate whether the respondents understand the questionnaire clearly or not. Testing of the question set for qualitative study was done as well. The reliability of questionnaire was calculated by using Cronbach’s alpha coefficient for perception part. The reliability index for the perception part (7 items) is 0.734. Feedback from the respondents was taken in for the modification before conducting the survey.

3.8 Data Collection

3.8.1 Quantitative data collection method

Data were collected through interviewing the respondents by the researcher and assistants who understand Myanmar language well using structured pre-tested questionnaire.

Research assistants were volunteers working in NMWD (network for migrant workers development), a community based NGO in Bang Khun Thian. They have had previous experience in quantitative survey data collection from other master students’ projects from Mahidol University. There were 3-4 assistants and all of them are at least

high school graduate from Myanmar. The researcher gave detailed training to them before helping out with quantitative data collection for this project.

The field supervisor was researcher herself and I went together with research assistants during the data collection. The researcher was in the field all the time during the data collection so that she can supervise the assistants in case they needed any verification or questions. The participants were approached via volunteers who are working under NMWD. The interview was conducted in the participants' home.

Before collecting data from the respondents, the researcher and assistant researchers gave clear verbal explanation to each potential respondent on the purposes of the study. Each respondent was informed that participation in this study is completely voluntary and informed consent was obtained from the respondents who are willing to participate in this study. Interview time was around 45 minutes. Structured pre-tested questionnaire that are translated to Burmese language with formal valid check was used.

We took the confidentiality of the participant's information including legal status as highest priority of the project. The research team was trained not to release any information of participants to anyone not related to the project. The recorded data was deleted after the project. The participant code was used instead of name of the participants.

3.8.2 Qualitative data collection method

After quantitative data collection, the 6 participants were selected in order to do in-depth interviewing. The participants of different rage of response from quantitative data collection were chosen. It was according to the response nature of ownership of CMHI, usage of CMHI card, very low perception to health services score, very high perception to health services score, high accessibility response, low accessibility response, low income, high income from quantitative study

In-depth interview of selected persons was done with guideline question set. Before interview, researcher introduced herself and explained about the research process to the respondents. Respondents were informed about the confidentiality of the answers are highest priority of the research. Interviewer informed about the duration of the interview which will be around 30 – 45 minutes. Respondents were asked back whether they have any questions regarding the process and anything that they want to clarify. And informed consent was taken from the respondents.

When the respondent felt relaxed and ready, the researcher started the interview with open question regarding the issue of the study. Interview was done with preplanned question set shown in appendix D. Factual questions were asked before the opinion related questions. Probes questions were used when necessary.

Although the question set was preplanned, the conversation was semi-structured format. Researcher listened attentively to the respondent with follow up question to understand and seek clarity for which being said during the interview.

Researcher guided the respondents only not to go to the different area of the answer throughout the entire interview. The interview took around 30 – 45 minutes and data was collected by audio-recorder and field notes. Written notes included observations of both spoken and non-spoken behaviors of the respondents. All recoded tape and data were deleted after the research.

3.9 Data analysis

3.9.1 Quantitative data analysis

Data was be organized and analyzed by the researcher using SPSS for quantitative study.

Descriptive statistics such as frequency, percentage was used for socio-demographic variables, working condition, medical disease, accessibility to health care services and perception. We used analytic statistics test; Pearson's Chi-square test to identify the relationship between sociodemographic characteristics and ownership of CMHI, medical condition and ownership of CMHI, working conditions and ownership of CMHI, accessibility of health services and ownership of CMHI, perception to health services and ownership of CMHI, sociodemographic characteristics and usage of CMHI, medical condition and usage of CMHI, working conditions and usage of CMHI, accessibility of health services and usage of CMHI, perception to health services and usage of CMHI.

3.9.2 Qualitative data analysis

After in-depth interview with the participants, the qualitative data were organized manually and examined carefully. Researcher order, categorize, label with same characteristics for data set. Content data analysis, interpretation, and conclusion of the results were done.

3.10 Ethical consideration

- Before conducting the research, approval from the Ethical committee of College of Public Health Science, Chulalongkorn University was obtained.
- Before interviewing the respondents, the researcher and assistant researchers gave clear verbal explanation to each potential respondent on the purposes of the study.
- Each respondent were informed that participation in this study is completely voluntary and informed consent was obtained from the respondents who were willing to participate in this study.
- Respondents were informed that their privacy is protected and data were kept confidential and anonymity was maintained throughout the research process.
- In addition, their personal data was respected and culturally sensitive questions were not included in this study.

CHAPTER IV
RESULTS

This chapter presents the results of data analysis, and is divided into three main sections: (1) descriptive information, (2) analytical findings; relationship among quantitative variables, and (3) analysis of qualitative data information.

The first two sections present findings from quantitative analysis and the findings of qualitative data results from in-depth interview will be presented together with the findings from quantitative analysis.

4.1 Descriptive information

4.1.1 Socio demographic characteristics

Socio demographic characteristics are described in table 1. A total of 400 migrant workers were interviewed. The age of respondents ranged from 18 to 58 years. 55.5 % were males and 44.5 were females.

As there were many ethnic groups in Myanmar, Burmese being main ethnicity and many more. We enquired the percentage of ethnic groups of Myanmar migrants in Bang Khun Thian as well. Half of respondents (52.5%) were Burmese and second most common ethnicity (14.7%) was Rakhine. There was 8.5 % Karen ,7 % Mon and Shan were 1.3%. The others were Dawei, Paoh and Gorkha (gawrakhar). The main difference between ethnicity are the language they used and their identity. But most of them understand Burmese as it is the main language used in all over Myanmar.

Regarding the marital status, 59% of the respondents were married and 36.5% were single. 2.3% were divorced, 0.5% widowed and 1.7% co-habit.

For educational achievement, 42.7% of respondents had achieved middle school education (%). 34.3% got primary school education. 16.3 reached to high school and 3.3% attained higher education. But another 3.3% don't have any education or never go to school.

For duration of stay, 55.7% has been living in Thailand for more than 1 year but less than 5 years. 34.0% has been living in Thailand over 5 years but 10.0% has only lived here for less than a year.

Occupation among the migrants of the survey, over two third of the respondents (80.7%) were working in factories and only 1.5% is construction worker. 7.5% were unemployed and 10.3% are others types of occupation such as shop vendor, waiter or waitress in restaurants.

Regarding average monthly income 54.7% earned more than 9,000 Thai Baht when 34.7% earned from 6,000 – 8,000 Thai Baht.

For Thai language skills, 71.3% of the respondents could communicate basically and 14.3% could not communicate at all.

Average person living in the same house is 2 and ranged from 1 to 6 persons. It can be seen from table 1 that around 80.0% of Myanmar migrant workers were registered and the remaining were unregistered.

Table 1 Socio-demographic characteristics of the respondents

Variables	**Frequency**	**Percentage**
Age (n=400)		
18-29	236	59
30-39	129	32.3
> 40	35	8.7
Gender (n=400)		
male	222	55.5
female	178	44.5
Ethnicity (n= 400)		
Burmese	210	52.5
Karen	34	8.5
Mon	28	7
Rakhine	59	14.7
Shan	5	1.3
others	64	16.0
Marital status (n= 400)		
single	146	36.5
married	236	59.0
divorced, separated	9	2.3
widowed	2	0.5
cohabit	7	1.7

Table 1 (continued) Socio-demographic characteristics of the respondents

Variables	Frequency	Percentage
Education achievement (n= 400)		
no education	13	3.3
primary	137	34.3
Middle school	171	42.7
high school	65	16.3
Higher education	13	3.3
others	1	0.3
Stay in Thailand (n= 399)		
<1 year	40	10.0
1-5 years	223	55.7
>5 years	136	34.0
Average monthly income (n= 398)		
no income	29	7.3
<5,000 THB	11	2.7
6,000 – 8,000 THB	139	34.7
> 9,000 THB	219	54.7
Occupation (n= 400)		
factory worker	323	80.7
construction worker	6	1.5
unemployed	30	7.5
others	41	10.3
Number of people living in the same household (n= 400)		
1	35	8.7
2	185	46.3
3	116	29.0
4	44	11.0
5	14	3.5
6	6	1.5
Thai language skills (n= 400)		
cannot speak at all	57	14.3
Can speak basically	285	71.3
Can speak Thai fluently but cannot read / write	48	12.0
Fluent in Thai language / can read and write	10	2.5
Registration status (n= 400)		
yes	319	79.7
no	81	20.3

4.1.2 Medical condition

Medical conditions of the respondents were shown in Table 2. Regarding medical conditions of the respondents, 90.0% doesn't have any disease diagnosed by medical personal and 7.0% has disease diagnosed by medical personnel. But 3.0% of the respondents do not know whether they have any diseases or not. In the last 6 months, 15.7%% of the respondents has illness or diseases such as diarrhea, fever, coughing, appendicitis, heart disease, hypertension, etc. when 84.0 % of the respondents does not have any illness. (Table 2)

Table 2 Medical conditions

Diseases diagnosed by medical personnel (n= 400)	**Frequency**	**Percentage**
Don't know	12	3.0
Yes	28	7.0
No	360	90.0
Any illness during last 6 months (n= 400)		
Don't know	1	0.3
yes	63	15.7
no	336	84.0

4.1.3 Working condition

Jobs changed during the time living in Thailand ranged from 0 to 20 jobs. More than half of the respondents (59.2%) have 8 working hours and 13.0 % has working hours 12 hours. Others have variation from 1-15 hours. Working days were ranged from 1 day to 7 days and 86.3 % were working 6 days per week. Half of the respondents have been less than 1 year in current job. 38.7% has been in the job for more than 1 year but less than 5 years when 2.0 % has been working at the same job for more than 5 years. (Table 3)

As shown in Table 4, the people who stay long enough in Thailand has more registration status than people who has only stayed Thailand for less than 1 year.

Table 3 Working conditions

Duration in this current job (n= 370)	**Frequency**	**Percentage**
less than 1 year	207	51.7
1-5 year	155	38.7
more than 5 year	8	2.0
Working days in a week (n= 368)	**Frequency**	**Percentage**
1	2	0.5
5	1	0.3
6	345	86.3
7	20	5.0

Table 4 Registration status and duration of stay

	Duration of stay		
	<1 year	1-5 years	>5 years
Do you have registration card?			
Yes (n= 319)	23 (5.8%)	179 (44.9%)	116 (29.1%)
no (n= 81)	17 (4.3%)	44 (11.0%)	20 (5.0%)

4.1.4 Accessibility to health services

Accessibility to health care services is presented in table 5. Although questionnaire used in this study includes 10 questions for accessibility, some respondents had never visit the health centers and they couldn't give reply to some questions. So we collected the answers with don't know option. Out of 400 respondents, 285 persons (71.3%) have been to the hospital but 115 respondents have never been to the hospital. Among those who had been to hospital, 57.0% had gone for themselves and 16.5% for the family or friend. Regarding the duration from home to health center, 40.3% took 15-30 minutes from their home to the hospital. And 17.0% took more than 30 minutes. 62.7% replied that the travelling cost is not expensive for them but 7.3% said it is expensive. Most of them, don't know the source of health information (36.5%). Some got the information from either work (22.0%) or friend (20.0%). Other received through family, neighbor, volunteer and social media. Waiting time at health center is 15-30 minutes for 26.7% and more than 30 minutes for 24.7%. Doctors' fee is not expensive for 46.3% of the

respondents. Main language used is Thai language being 68.7% among the response and 56.5% stated that hospital provided them with the translator. Regarding the general satisfaction, 55.5% stated that they are satisfied with the services at the health center. (Table 5)

Table 5 Accessibility to health services

Variables	Frequency	Percentage
Have you ever been to hospital (n=400)		
yes	285	71.3
no	115	28.7
For yourself or For your family/friend (n=294)		
myself	228	57.0
friend/family	66	16.5
Duration of home to health center (n= 400)		
Don't know	135	33.7
less than 15 min	36	9.0
15-30 min	161	40.3
more than 30 mins	68	17.0
Is the travelling cost expensive for you? (n= 400)		
Don't know	120	30.0
Yes	29	7.3
No	251	62.7
Where or from whom did you receive the information about health services? (n= 400)		
Don't know	146	36.5
Friend	80	20.0
Family	32	8.0
Work	88	22.0
Community, neighbor	28	7.0
Volunteer	21	5.3
Social media	5	1.3
How long do you have to wait to see physician at health center? (n= 399)		
Don't know	160	40.0
Less than 15 min	33	8.3
15-30 min	107	26.7
More than 30 mins	99	24.7
No response	1	0.3

Table 5 (continued) Accessibility to health services

Variables	Frequency	Percentage
Is doctors' fee expensive for you? (n= 400)		
Don't know	137	34.3
Yes	78	19.5
No	185	46.3
What language is used in health center (n= 400)		
Don't know	111	27.7
Thai	275	68.7
English	2	0.5
Burmese	12	33.0
Does the hospital provide you with translator? (n= 399)		
Don't know	113	28.3
Yes	226	56.5
No	60	15.0
Are you satisfied with health service at health center (n= 400)		
Don't know	135	33.7
Yes	222	55.5
No	43	10.7

4.1.5 Perception towards health services

Table 6 showed the response to the statements regarding perception towards health service. The statements were asked for the response were in the scale of strongly disagree, disagree, not sure, agree and strongly agree.

Table 6 : Perception towards health services

Statements for perception towards health services	Frequency	Percentage
Health services provided at the hospital are sufficient for the migrant health problems (n= 400)		
strongly disagree	21	5.3
disagree	76	19.0
not sure	148	37.0
agree	146	36.5
strongly agree	9	2.3
The service providers in the hospital are kind and helpful to the migrant workers (n= 400)		
strongly disagree	15	3.7
disagree	63	15.7
not sure	132	33.0
agree	176	44.0
strongly agree	14	3.5

Table 6 (continued) Perception towards health services

Statements for perception towards health services	Frequency	Percentage
CMHI card is useful and essential for everyone (n= 400)		
strongly disagree	24	6.0
disagree	28	7.0
not sure	66	16.5
agree	238	59.5
strongly agree	44	11.0
CMHI card is not expensive for the migrants (n= 400)		
strongly disagree	42	10.5
disagree	124	31.0
not sure	103	25.7
agree	122	30.5
strongly agree	9	2.3
I can understand the explanation of the doctor and nurses (n= 400)		
strongly disagree	16	4.0
disagree	64	16.0
not sure	148	37.0
agree	160	40.0
strongly agree	12	3.0
An interpreter is needed for the translation of the language. (n= 400)		
strongly disagree	18	4.5
disagree	44	11.0
not sure	74	18.5
agree	229	57.3
strongly agree	35	8.7
You are satisfied with the health services provided in the hospital (n= 400)		
strongly disagree	19	4.7
disagree	56	14.0
not sure	126	31.5
agree	192	48.0
strongly agree	7	1.7

As shown in Table 6, for the statement ‘Health services provided at the hospital are sufficient for the migrant health problems’ 36.5% of the respondents answered ‘agree’ and 37.0% of the respondents replied ‘not sure’. Regarding the statement ‘The service providers in the hospital are kind and helpful to the migrant workers’, 44.0% of

the respondents agree with this statement. More than half of the respondents (59.0%) agreed the statement ‘CMHI card is useful and essential for everyone’ and only 6% of the respondents disagree of this statement. For the statement ‘CMHI card is not expensive for the migrants’, 30.0% of the respondents chose agree and another 31.0% of the respondents chose to disagree. Regarding the statement ‘I can understand the explanation of the doctor and nurses’, 40.0% of the respondents agree for this statement. More than half of the respondents (57.3%) chose ‘agree’ for the statement ‘An interpreter is needed for the translation of the language’. For the statement, ‘You are satisfied with the health services provided in the hospital’, nearly half of the respondents agreed which is 48.0% and only 4.7% of the respondents strongly disagree for this statement.

Table 7 Perception score for responses of the statements

Perception score (n= 400)	**Percentage**
High perception	11
moderate perception	54.5
low perception	34.5

Table 7 showed the scores of perception (high, moderate, and low) and 54.5 % had moderate perception score, 34.5% had low level of perception score and 11.0 % had high level of perception score. Perception means the respondents’ opinion of agree or disagree with the statement concerning the health care services towards migrant workers

Answers are categorized into five levels: strongly disagree, disagree, uncertain, agree and strongly agree. For the answer ‘strongly disagree’ got 1 score, the answer ‘disagree’ got 2 scores, the answer ‘uncertain’ got 3 scores, the answer ‘agree’ got 4 scores, the answer ‘strongly agree’ got 5 scores. There will be 7 questions with minimum score 1 and maximum score 5, the possible score ranges from 7 – 35 and the respondents’ perception is classified into three levels.

The cut-off point for “high level perception” was greater than 80% of total scores, that for “moderate-level perception” was from 60 – 80% and for “low-level perception” was less than 60% of total scores.

4.1.6 Ownership and Usage of Compulsory Migrant Health Insurance

Table 8 Registration status and ownership of CMHI

		Do you own CMHI card now or not?	
		Yes	No
Do you have registration card? (n= 400)	yes (n= 319)	174 (43.5%)	145 (36.2%)
	no (n=81)	28 (7%)	53 (13.2%)

Table 9 Ownership and Usage of CMHI

		Usage of CMHI	
		Yes	No
Do you own CMHI card now or not?	Yes (n= 202)	145 (36.2%)	174 (43.5%)
	No (n=81)	53 (13.2%)	28 (7%)

Table 8 was the cross tabulation between the registration status and ownership of CMHI card. Out of 319 respondents who had registration status, 43.5% own CMHI card now. But 36.2 % does not own the CMHI card now.

Table 9 described that ownership and usage of CMHI card. Out of 202 respondents owned CMHI card, 36.2% (145 respondents) use the card. Table 10 showed the channels that migrants buy CMHI card, 39% of the respondent bought CMHI by selves and 30% of the respondent by their employer. 3.5% of the respondent via friends and 1%via family.

Table 10 Buying channel for CMHI

If you own CMHI, who buy it for you? (n= 294)	**Frequency**	**Percentage**
myself	156	39.0
family	4	1.0
employer	120	30.0
friend	14	3.5

4.2 Analytic findings: Relationship among variables

The data analysis is to find out the relationship between independent and dependent variables. The relationship between independent variables, which are sociodemographic characteristics, medical condition, working condition, accessibility to health services and perception towards health services with dependent variable ownership of CMHI and usage of CMHI is done. The relationship was determined by Chi-square test. The level of significance for relationship between these variables was set at p value= 0.05.

4.2.1 The relationship between independent variables and ownership of CMHI

Table 11 shows the relationship between socio-demographic characteristics and ownership of CMHI. There was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, Thai language skills and educational achievement and ownership of CMHI card. There was an association between occupation and ownership of CMHI card with p-value = 0.019

Table 11 Relationship between sociodemographic characteristics and ownership of CMHI

Sociodemographic characteristics (n=400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
Age					
19-29	115	(28.8)	121	(30.2)	0.687
30-39	68	(17.0)	61	(15.2)	
>40	19	(4.8)	16	(4.0)	
Gender					
Male	118	(29.5)	104	(26.0)	0.236
Female	84	(21.0)	94	(23.5)	

Table 11 (continued) Relationship between sociodemographic characteristics and ownership of CMHI

Sociodemographic characteristics (n=400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
Ethnicity					
Burmese	105	(26.2)	105	(26.2)	0.294
Karen	14	(3.5)	20	(5.0)	
Mon	17	(4.2)	11	(2.8)	
Rakhine	25	(6.2)	34	(8.5)	
Shan	3	(0.8)	2	(0.5)	
Others	38	(9.5)	26	(6.5)	
Marital status					
Single	69	(17.2)	67	(16.8)	0.544
Married, cohabit	120	(30.0)	123	(30.8)	
Divorced, separated, widowed	13	(3.2)	8	(2.0)	
Number of people living in the same house					
Less than 3 persons	174	(43.5)	162	(40.5)	0.239
More than 3 persons	28	(7.0)	36	(9.0)	
Average monthly income					
<5,000 THB	20	(5.0)	23	(5.8)	0.106
6,000 - 8,000 THB	64	(16.1)	81	(20.4)	
> 9,000 THB	116	(29.1)	94	(23.6)	
Occupation					
factory worker	173	(43.2)	150	(37.5)	0.019
Non factory worker	15	(3.8)	32	(8.0)	
Unemployed	14	(3.5)	16	(4.0)	

Table 11 (continued) Relationship between sociodemographic characteristics and ownership of CMHI

Sociodemographic characteristics (n=400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
Stay in Thailand					
<1 year	18	(4.5)	22	(5.5)	0.666
1-5 years	112	(28.1)	111	(27.8)	
>5 years	72	(18.0)	64	(16.0)	
Thai Language skill					
Cannot speak at all	29	(7.2)	28	(7.0)	0.975
Can speak basically	143	(35.8)	142	(35.5)	
Can speak Thai language fluently	30	(7.5)	28	(7.0)	
Educational achievement					
Primary school or less	66	(16.5)	84	(21.0)	0.053
Middle school	98	(24.5)	73	(18.2)	
High school and above	38	(9.5)	41	(10.2)	

Table 12 Relationship between medical condition and ownership of CMHI

Medical condition (n = 400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
Diseases diagnosed by medical staff					
Yes	13	(3.2)	15	(3.8)	0.655
No/ Don't know	189	(47.2)	183	(45.8)	
Any illness during last 6 months?					
Yes	37	(9.2)	26	(6.5)	0.155
No/ Don't know	165	(41.2)	172	(43.0)	

Table 12 showed the relationship between medical conditions and ownership of CMHI. Having a disease diagnosed by medical personnel and having an illness during last 6 months ago are not associated with ownership of CMHI card.

Table 13 Relationship between working condition and ownership of CMHI

Working condition (n = 400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
Do you have registration card?	174	(43.5)	145	(36.2)	0.001
Yes	28	(7.0)	53	(13.2)	
No					
Duration in current job					
less than 1 year	101	(27.3)	106	(28.6)	0.321
more than 1 year	88	(23.8)	75	(20.3)	

Table 13 describes the relationship between working condition and ownership of CMHI. There is significant association between registration status and ownership of CMHI card with p-value = 0.001. Duration in current job is not associated with ownership of CMHI card.

Table 14 showed relationship between the accessibility towards health services and ownership of CMHI card.

Been to the hospital before, doctors' fee, waiting time, translator services and general satisfaction towards health services are highly associated with ownership of CMHI with p-value < 0.001.

Table 14 Relationship between accessibility and ownership of CMHI

Accessibility towards health services (n = 400)	**Frequency (%) of ownership of CMHI**				***p-value***
	Yes		**No**		
Have you ever been to hospital?					
Yes	172	(43.0)	113	(28.2)	<0.001
No	30	(7.5)	85	(21.2)	
Duration of home to health center					0.341
less than 15 min	18	(6.8)	18	(6.8)	
15-30 min	98	(37.0)	63	(23.8)	
more than 30 mins	36	(13.6)	32	(12.1)	
Is the travelling cost expensive for you?					
Yes	12	(3.0)	17	(4.2)	0.308
No / Don't know	190	(47.5)	181	(45.2)	
Is doctors' fee expensive for you?					
Yes	24	(6.0)	54	(13.5)	<0.001
No	178	(44.5)	144	(36.0)	
Waiting time at health center					
less than 15 min	21	(8.8)	12	(5.0)	0.926
15-30 min	64	(26.8)	43	(18.0)	
more than 30 mins	60	(25.1)	39	(16.3)	
language is used in health center					
Thai	166	(57.4)	109	(37.7)	0.067
Burmese/ English	5	(1.7)	9	(3.1)	
Translator presence or not					
Yes	138	(34.6)	88	(22.1)	<0.001
No	64	(16.0)	109	(27.3)	
General satisfaction					
Yes	130	(32.5)	92	(23.0)	<0.001
No	72	(18.0)	106	(26.5)	

Table 15 Relationship between perception score towards health services and ownership of CMHI

Perception towards health services score (n = 400)	**Frequency (%) of ownership of CMHI**				
	Yes		**No**		***p-value***
High perception	25	(6.2)	19	(4.8)	0.076
Moderate perception	118	(29.5)	100	(25.0)	
Low perception	59	(14.8)	79	(19.8)	

Table 15 stated the relationship between the ownership and perception score towards health services. The perception score and ownership are not associated with p-value 0.076.

4.2.2 The relationship between independent variables and usage of CMHI

Table 16 Relationship between sociodemographic characteristics and usage of CMHI

Sociodemographic characteristics (n= 202)	**Frequency (%) of Usage of CMHI**				
	Yes		**No**		**p-value**
Age					
19-29	58	(28.7)	57	(28.2)	0.441
30-39	39	(19.3)	29	(14.4)	
>40	8	(4.0)	11	(5.4)	
Gender					
Male	64	(31.7)	54	(26.7)	0.447
Female	41	(20.3)	43	(21.3)	
Ethnicity					
Burmese	53	(26.2)	52	(25.7)	0.452
Karen	7	(3.5)	7	(3.5)	
Mon	7	(3.5)	10	(5.0)	
Rakhine	11	(5.4)	14	(6.9)	
Shan	2	(1.0)	1	(0.5)	
others	25	(12.4)	13	(6.4)	

Table 16 (continued) Relationship between sociodemographic characteristics and usage of CMHI

Sociodemographic characteristics (n= 202)	**Frequency (%) of Usage of CMHI**				
	Yes		**No**		**p-value**
Marital status					
Single	33	(16.3)	36	(17.8)	0.696
Married, cohabit	65	(32.2)	55	(27.2)	
Divorced, separated, widowed	7	(3.5)	6	(3.0)	
Number of people living in the same house					
Less than 3 persons	93	(46.0)	81	(40.1)	0.298
More than 3 persons	12	(5.9)	16	(7.9)	
Average monthly income					
<5,000 THB	8	(4.0)	12	(6.0)	0.167
6,000 - 8,000 THB	39	(19.5)	25	(12.5)	
> 9,000 THB	57	(28.5)	59	(29.5)	
Occupation					
factory worker	89	(44.1)	84	(41.6)	0.595
Non factory worker	7	(3.5)	8	(4.0)	
Unemployed	9	(4.5)	5	(2.5)	
Stay in Thailand					
<1 year	11	(5.4)	7	(3.5)	0.505
1-5 years	60	(29.7)	52	(25.7)	
>5 years	34	(16.8)	38	(18.8)	
Thai Language skill					
Cannot speak at all	14	(6.9)	15	(7.4)	0.867
Can speak basically	76	(37.6)	67	(33.2)	
Can speak Thai language fluently	15	(7.4)	15	(7.4)	
Educational achievement					
Primary school or less	38	(18.8)	28	(13.9)	0.538
Middle school	48	(23.8)	50	(24.8)	
High school and above	19	(9.4)	19	(9.4)	

Table 16 showed the relationship between sociodemographic characteristics and usage of CMHI card. There was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, occupation, Thai language skills and educational achievement and usage of CMHI card.

Table 17 Relationship between medical conditions and usage of CMHI

Medical condition (n = 202)	**Frequency (%) of Usage of CMHI**				
	Yes		**No**		***p-value***
Diseases diagnosed by medical staff					
Yes	9	(4.5)	4	(2.0)	0.198
No/ Don't know	96	(47.5)	93	(46.0)	
Any illness during last 6 months?					
Yes	25	(12.4)	12	(5.9)	0.036
No/ Don't know	80	(39.6)	85	(42.1)	

Table 17 demonstrates the relationship between medical conditions of the respondents and usage of CMHI card. Disease diagnosed by medical staff is not associated with the usage of CMHI card whereas illness during last 6 months is associated significantly with usage of CMHI by p-value = 0.036.

Table 18 Relationship between working conditions and usage of CMHI

Working condition (n = 202)	**Frequency (%) of Usage of CMHI**				
	Yes		**No**		***p-value***
Do you have registration card?					
Yes	90	(44.6)	84	(41.6)	0.856
No	15	(7.4)	13	(6.4)	
Duration in current job					
less than 1 year	56	(29.6)	45	(23.8)	0.224
more than 1 year	41	(21.7)	47	(24.9)	

Relationship between working conditions and usage of CMHI card is shown in table 18. Duration in current job and registration status are not associated with usage of CMHI card.

Table 19 Relationship between accessibility and usage of CMHI

Accessibility towards health services (n = 202)	**Frequency (%) of usage of CMHI**				
	Yes		**No**		***p-value***
Have you ever been to hospital?					
Yes	104	(51.5)	68	(33.7)	<0.001
No	1	(0.5)	29	(14.4)	
Duration of home to health center					
less than 15 min	9	(5.9)	9	(5.9)	0.804
15-30 min	57	(37.5)	41	(27.0)	
more than 30 mins	21	(13.8)	15	(9.9)	
Is the travelling cost expensive for you?					
Yes	8	(4.0)	4	(2.0)	0.294
No / Don't know	97	(48.0)	93	(46.0)	
Is doctors' fee expensive for you?					
Yes	14	(6.9)	10	(5.0)	0.507
No	91	(45.0)	87	(43.1)	
Waiting time at health center					
less than 15 min	16	(11.0)	5	(3.4)	0.143
15-30 min	38	(26.2)	26	(17.9)	
more than 30 mins	31	(21.4)	29	(20.0)	
language is used in health center					
Thai	99	(57.9)	67	(39.2)	0.987
Burmese/ English	3	(1.8)	2	(1.2)	
Translator presence or not					
Yes	83	(41.1)	55	(27.2)	0.001
No	22	(10.9)	42	(20.8)	
General satisfaction					
Yes	83	(41.1)	47	(23.3)	<0.001
No	22	(10.9)	50	(24.8)	

Table 19 described the relationship between the accessibility and usage of CMHI card. The accessibility variables (Been to hospital or not, translation services presence or not and general satisfaction towards health services) and usage of CMHI card are highly associated significantly with p-value <0.001.

Table 20 Relationship between perception towards health services and usage of CMHI

Perception towards health services score (n = 202)	**Frequency (%) of usage of CMHI**				
	Yes		**No**		***p-value***
High perception	14	(6.9)	11	(5.4)	0.059
Moderate perception	68	(33.7)	50	(24.8)	
Low perception	23	(11.4)	36	(17.8)	

Table 20 showed the relationship between perception scores and the usage of CMHI card. Perception level and usage of CMHI are not associated significantly.

4.3 Qualitative data analysis

(1) Accessibility towards health services

Accessibility towards health services was explored in terms of the affordability, waiting time, language barrier and general satisfaction towards health services. Regarding affordability, the respondents mentioned that the cost for the CMHI scheme is expensive because they need to pay together with the registration process and other expenses such as work permit, passport renewal, etc. But in regarding the doctors' fee and costs at the hospital, it is in the affordable range of the migrants. For waiting time, they need to wait for the doctor depending on the queue number they received upon arrival. They need to wait a bit for processing when using the CMHI card. For language barrier, the hospital provided the migrants with the interpreter and the communication between the interpreter and migrants has some level of difficulty if they are from different ethnicities. Most of the respondents satisfied with the services provided by the hospital.

The following are some of examples from the quotations by Myanmar migrants during in-depth interviews.

"....we can't get treatment for major illnesses. If we need to do blood tests, you need to pay 1,000 - 2,000 in addition to 30 Baht" 31 years old, male, factory worker, Thian Talay

"The card is very good for pregnant mothers, cost very little for delivery" 31 years old, male, factory worker, Thian Talay

"If you have fever, you can get certificate by doctor to show to your employer" 31 years old, male, factory worker, Thian Talay

"There are 3 translators but Myanmar migrants have many different ethnic groups so we need different translators" 27 years old, male, factory worker, Thian Talay

"There is some difficulty in understanding the language" 27 years old, male, factory worker, Thian Talay

(2) Perception towards health services

The respondents stated that the quality health services they received in Thailand are much better than compared to in Myanmar. Having CMHI card also benefit them as it will only cost them 30 Baht when they visit to hospital but when in Myanmar, the cost will be mostly out of pocket payment. Doctors and nurses at the hospital cared for the migrants. There is some difficulty during the major operations and hospital admission due to the financial difficulty and language difference. The assistance of translator is highly required for the migrants because although they can communicate basic Thai language, when it comes to medical problems, they cannot explain enough to doctors and nurses. Please see the following examples from qualitative in-depth interview expressed in regards to perception towards health services and experiences of migrants.

"I have been to hospital for my baby delivery. They welcomed me very well. The nurses and doctors took care of me very well." 25 years old, female, factory worker, Thian Talay

"I felt some discrimination if we go with Longyi (the traditional Burmese attire) *or wear Thanaka* (yellow paste that woman wears on the face*)."* 25 years old, female, factory worker, Thian Talay

"We've been told that hospital staffs do not understand the way we speak Thai" 27 years old, male, factory worker, Thian Talay

(3) Ownership and usage

Most of the people owned the CMHI insurance card through the registration process and they continue to renew it. We found out during the interviews is that even though they own the CMHI card, they do not know the information regarding coverage details and services excluded from the card. The migrant still lack the knowledge about the benefits of having the insurance in hand. For the usage, the migrants are in age group of healthy adult who are in between 19-39, therefore they are healthy and do not have to go to hospital as much as older unhealthy individuals may need to go. The following examples statements are the qualitative information regarding ownership and usage of CMHI.

"I still do not know about the details of services covered by CMHI card" 25 years old, female, factory worker, Thian Talay

"*This card is mostly bought by the pregnant ladies."* 25 years old, female, factory worker, Thian Talay

"Mostly people do not use this card because we need to wait for a long time" 25 years old, female, factory worker, Thian Talay

"We use this card because some factories give day-offs after the doctor's certificate and get daily wage." (31 years old, Male, Factory worker, Thian Talay)

"I used this card because my factory gave money for my delivery but other factories did not give money for this kind" (25 years old, Female, factory worker, Thian Talay)

CHAPTER V
DISCUSSION

5.1 Discussion

The research on "Perception and Usage of Compulsory Migrant Health Insurance Scheme among Myanmar migrant workers in Bang Khun Thian district, Bangkok Metropolitan Area, Thailand" was a cross-sectional descriptive study applying both quantitative and qualitative research methods. The study was done in Bang Khun Thian district from May to June 2015 towards Myanmar Migrant workers residing in that area. Quantitative data collection was done by structured questionnaire. Qualitative in-depth interviews were done with 6 migrant workers chosen by the nature of their response towards quantitative questionnaire.

Among the 400 adult Myanmar migrant workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand, the age range is from 18 to 58. This result matches with the expectation as the migrant population is workforce population which migrates to Thailand by seeking job opportunity. In current research, 55.5% are male and 44.5% are female. Most of them were Burmese and Rakhine. As Burmese is the main ethnic group in Myanmar (Burma), it is also main ethnic group in Myanmar migrants in Thailand. We found 8.5% Karen and 7% Mon in Bang Khun Thain district. This information is consistent with the finding presented in Thailand Migration report 2014 by International Organization for Migration (IOM).(Huguet & IOM, 2014) But in the studies done in Ranong, the main ethnic groups are Burmese and Dawei considering the state in Myanmar closer to Ranong is the place for Dawei people. (Aung, 2008)

Half of the respondents (59%) were married and 36.5 % were single. Educational level of the majority was in middle school education level and primary school level. Around half of them stayed in Thailand in between 1-5 years. Just a bit over half of the respondents have the income of 9,000 Baht per month. Around 35% has the income of 6,000 – 8,000 Thai Baht.

We also observed that there were many factories in Bang Khun Thian area and over two third of respondents are working as factory workers. For Thai language skills,

around 71.3% can communicate basically although 14.3% cannot speak Thai language at all. Average person living in a household is 2 persons and ranged from 1-6 persons.

80% of the respondents in the survey were registered and the remaining was unregistered. It is consistent with the study done for Myanmar migrants by IOM, 2013 namely assessing potential changes in migration pattern. In that study, the majority of the migrants were fully documented (64.6%), followed by temporarily documented (18.3%) and undocumented (12.7%), while another (4.4%) had colored cards issued by the Thai Government. (Chantavanich & IOM, 2013)

Regarding medical conditions of the respondents, 90.0% does not have any disease diagnosed by medical personnel and only 7.0% has disease diagnosed. And 3.0% does not know whether they have the disease or not. In the last 6 months, 15.7% has illness or disease and 84.0% does not have any illnesses.

Jobs changed during the time living in Thailand ranged from 0-20 jobs. More than half of the respondents have 8 working hours and around 13% have 12 hours. Others work between 1-15 hours. Majority of the respondents work 6 days per week. And this is the reason why we can do the data collection only on Sunday which is the only holiday for most of the migrants. Nearly 40% has been at their job in between 1-5 years but very less people stayed in the same job for more than 5 years (2.0%).
Regarding accessibility towards health services, we found that out of 400 respondents, 285 persons had been to hospital. Among those who had been to the hospital, 57.0% had gone for themselves and other for friends or family. 40.3% of the respondents took 15-30 minutes duration of travelling from their home to the hospital. Nearly 62.7% responded that travelling cost is not expensive for them. We found out that their option for commuting can be by bus, mini shuttle bus or taxi. Most of them don't know the source of health information but some got the information either from work or friend. Very less number of respondents received health information from volunteers which means we need to enforce the work of volunteers and community based organization.

Waiting time at the health center is 15-30 minutes for 26.7% and more than 30 minutes for 24.7%. Doctors' fee is not expensive for 46.3 % of the respondents. This finding can be due to their CMHI coverage. Main language used is Thai language as the response was 68.7% and around half of the respondents stated that hospitals provide them with translator. But according to the findings from qualitative interview, the

difference between ethnicity of translator and the respondents can affect the communication between doctors and patients. For example, Translator being Karen and respondents being Rakhine which are very different ethnic groups in terms of language and their fluency in Burmese should be tested as well.

Regarding the general satisfaction, half of the respondents are satisfied with the services from health center. For perception towards health services, half of the respondents showed moderate level of perception which means they replied between 60-80% of the score. 34.5% had low level of perception score and 11.0% had high level of perception. Out of 400 respondents, 202 respondents own the CMHI card. 145 respondents used CMHI card out of 202 CMHI owners in our study. This usage can be influenced by the fact that the migrants are in the age group of young adults and adults who are in healthy condition and we also found out that 84.0% of the respondents does not have any illness during last 6 months.

When co-relating with qualitative answers, the respondents have moderate level of perception score, the following are some wishes from them that they wants regarding CMHI card issues. Please see the followings;

25 years old, female, dependent, Thian Talay gave the following quotes regarding her wishes towards CMHI.

"We want to have more Myanmar doctors or nurses here so that the language problems will get easy"

"I want to have the translator helps us more, explains more details"

"The card is expensive and if it is cheaper, everyone can have access to it"

When calculating relationship between socio-demographic characteristics and ownership of CMHI, we found out that there was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, Thai language skills and educational achievement and ownership of CMHI card. There was an association between occupation and ownership of CMHI card with p-value = 0.019.

This finding is not consistent with the findings from the study by Lan Le My done at Hanoi in 2012 that the results revealing gender and age, educational level, economic status, health status and occupation have significantly impact on the enrollment in voluntary scheme except for occupation (My & Damrongplasit, 2012)

Regarding working conditions and ownership of CMHI, the registration status and ownership is highly associated with p-value – 0.001. But since this CMHI scheme is compulsory when the migrants come for registration, this finding is as expected. Duration in current job is not associated with ownership.

When calculating accessibility towards health services and ownership of CMHI card, Been to the hospital before, doctors' fee, waiting time, translator services and general satisfaction towards health services are highly associated with ownership of CMHI with p-value < 0.001.

These findings are consistent with a study by Shubhamoy Ghosh in 2014. That study was to find out Access to and Utilization of the Health Services among the Patients in a Government Homeopathic Hospital in West Bengal, India which reveals utilization of the health services were influenced by understanding of Bengali language ($P < 0.05$).(Ghosh, Saha, & Koley, 2014)

The perception towards health services score and ownership are not associated. It may be because migrants can buy the compulsory migrant health insurance when they are in registration process.

Regarding relationship between sociodemographic characteristics and usage of CMHI card, there was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, occupation, Thai language skills and educational achievement and usage of CMHI card. This finding is different with the findings from a study by Shubhamoy Ghosh , 2014 in Bangladesh where utilization of the health services were influenced by residence and monthly household income ($P < 0.05$). (Ghosh et al., 2014)

The relationship between medical conditions and usage of CMHI card, disease diagnosed by medical personal is not associated with the usage of CMHI card. But having an illness during last 6 months is associated significantly with usage of CMHI by p-value = 0.036. This can be explained by that when a person has a disease or illness, they will go to hospital and will use insurance card if they have one. When the migrants are healthy, they will not use the card even if they own one.

This finding is also consistent with the finding in a study done in Jordan by Abdullah Alkhawaldeh which is many factors were associated with PHC service

utilization, the strongest predictor of PHC service utilization was chronic illnesses.(Alkhawaldeh et al., 2014)

For relationship between working conditions and usage of CMHI card, duration in current job and registration status are not associated with usage of CMHI card.

When calculating, the relationship between the accessibility and usage of CMHI card, the variables such as been to hospital or not, translation services presence or not and general satisfaction towards health services and usage of CMHI card are highly associated significantly with p-value <0.001. There is no relationship between perception scores and the usage of CMHI card. We can conclude that having no difficulty in communicating with the presence of translator and having general satisfaction towards health services results in increased usage of CMHI card. The rate of usage of CMHI card is influenced by whether the respondents are healthy or not. The usage can be low when the respondents are in age group of young adults with no illness during last 6 months.

CHAPTER VI
CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This study was done in Bang Khun Thian district, Bangkok Metropolitan Area, Thailand. A total of 400 Myanmar migrant workers who were working as factory workers, shop vendor sellers and construction workers participated in the study. Quantitative Data was collected by using structured questionnaire during May and June 2015. Qualitative in-depth interview of 6 migrant workers were done to know more details response from quantitative data.

The main objective of the study was to find out and study the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand. And the specific objectives were to explore the perception and usage of compulsory migrant health insurance and to find out the association of the socio-demographic characteristics, working conditions, medical condition, accessibility, health information and perception with ownership and with the usage of compulsory migrant health insurance scheme.

SPSS software was used for data analysis. Chi-square test was used to identify the relationship between independent variables and the ownership of compulsory migrant health insurance as well as independent variables and the usage of compulsory migrant health insurance scheme. For qualitative data, the analysis was done by tabulation, summarizing and drawing conclusion.

Age of the respondents ranged from 18 to 58 years and around half of the respondents were males. Half of the migrants were Burmese and second most common ethnicity was Rakhine. Others were Karen, Mon, Shan, Dawei, Paoh and Gorkha. 59% were married. The majority of migrants attained middle school education or primary school. Half of them had been in Thailand for 1-5 years and 10% had only been living in Thailand for less than 1 year. 54.7% had an average income of 9,000 Baht per month. 80% of the respondents were registered. Regarding Thai language skills, 71.3% can

speak basically. 90.0% had no disease diagnosed by medical personnel and 84.0% had no illness during last 6 months.

Most of them are staying in rented apartments. The majority of the migrants had 2 people staying together in their house with only 1 room which has 1 door, 2-3 windows and bathroom attached. Most of them are working 6 days a week with 8 hours a day.

For accessibility of health services, most of the migrants had been to the health services either with the reason for themselves or for their family or friend. And most of them were satisfied with the health center they visited.

In among the respondents with registration status, 43.5 % own CMHI card and they cannot have the CMHI without the registration card. 145 respondents used CMHI card out of 202 CMHI owners in our study. The most common buying channel for CMHI card is by migrant themselves (39.0%) and another is via employer which is 30.0%.

In this study, there was an association between type of occupation and ownership of CMHI card with p-value = 0.019. There is significant association between registration status and ownership of CMHI card with p-value = 0.001. Been to the hospital before, doctors' fee, waiting time, translator services and general satisfaction towards health services are highly associated with ownership of CMHI with p-value < 0.001. Having a disease diagnosed by medical personnel and having an illness during last 6 months ago are not associated with ownership of CMHI card. Duration in current job is not associated with ownership of CMHI card. The perception score and ownership are not associated.

For the relationship between sociodemographic characteristics and usage of CMHI card, there was no significant association between sociodemographic characteristics such as age, gender, ethnicity, marital status, number of people living in the same household, average monthly income, stay in Thailand, occupation, Thai language skills and educational achievement and ownership of CMHI card.

Disease diagnosed by medical staff is not associated with the usage of CMHI card whereas illness during last 6 months is associated significantly with usage of CMHI.

Registration status and working days in a week is not associated with usage of CMHI card.

The accessibility variables (Been to hospital or not, translation services presence or not and general satisfaction towards health services) and usage of CMHI card are highly associated significantly with p-value <0.001. Perception level and usage of CMHI are not associated significantly.

Overall findings suggested that the usage of CMHI card is associated with the occupation, having an illness, being healthy, translator assistance and satisfaction towards health services from hospital.

6.2 Limitations

- This study is done only in Bang Khun Thian district, Bangkok Metropolitan area so the findings could not be generalized to the whole Myanmar migrant workers populations in Thailand.
- As this is a cross sectional study, it cannot conclude the changes among migrant population overtime and cannot find out the causal factors
- Another limitation of the study is that we only have small number of in-depth interviews for qualitative data collection.

6.3 Recommendation

To improve the ownership and usage of compulsory migrant insurance scheme by adult Myanmar migrant workers, I would like to present the following recommendations.

Health education and health information to employers and workers so that they can understand the importance of insurance and go hand in hand to using the services provided by health system.

For Community based organization, migrants who are unemployed could be recruited and trained as community health volunteers so that they could help in giving out health information towards migrant community. The services already providing by CBO should also be strengthened.

Hospital staff and translators should be teamed up with local community based organizations to find out ways of sustainability towards usage of CMHI and to reduce obstacles that migrants faced during access to health services.

Raising awareness on compulsory migrant health insurance scheme: campaigns and usefulness, coverage benefits should be done. By doing so, we can educate the Myanmar Migrants the benefit of having insurance and its consequences.

Recommendation on further study

The cross sectional studies which compare the ownership and usage of CMHI among migrant groups in different province areas should be done.

Longitudinal studies to explore the factors influencing the ownership and usage of CMHI card should be done.

Qualitative studies on key persons such as employers, district health officers and community based volunteers should be undertaken as well.

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APPENDIX

APPENDIX A

Administration & Time Schedule

Research/project activities	Time frame (months during 2014-2015)						
	Oct	Nov	Jan-Feb	March	April	May	June-July
Literature review and Tool development for data collection							
Thesis proposal exam							
Ethical committee of CPHS approval							
Field preparation &data collection							
Data analysis							
Report writing, thesis examination, revision, publication							
Total							

Title of project: PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND

APPENDIX B

Estimated Budget

No.	Activities	Unit (Thai Baht)	Quantity	Total (Thai Baht)
1.	**Pre-test**			
	Questionnaire photocopy	10	30 sets	300
	Transportation	400	1 time	400
	Cleaning product(or)a bar of soap	20	30	600
				1,300
2.	**Data collection**			
	Questionnaire photocopy	10	550 sets	5,500
	Transportation	300	7 times	2,100
	Research assistants per diem	200	5 * 7 Days	7,000
	Meal one time	100	6 * 7 Days	4,200
	Cleaning product(or)a bar of soap	20	450	9,000
	Miscellaneous			1,000
				28,800
			Grand total	30,100

APPENDIX C

Form of Participant Information Sheet for quantitative survey

Title of research project "PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND"

Principle researcher's name Hnin Oo Mon
Position Master of Public Health Student

Home address 55/145, New Panasin Place, 24/3 Ramkhamheng, Huamark, Bangkapi, Bangkok, Thailand, 10240

Cell phone +66(0)813037033

E-mail: hnin88@gmail.com

1. You are being invited to take part in a research project. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and do not hesitate to ask if anything is unclear or if you would like more information.

2. This research project involves "perception and usage of compulsory migrant health insurance scheme among adult Myanmar migrant workers in Bang Khun Thian District, Bangkok Metropolitan area, Thailand"

3. Objective (s) of the project are;

   - To study and explore the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand
   - To find out the association of the socio-demographic characteristics, working conditions , medical condition, accessibility, health information and perception with the usage of compulsory migrant health insurance scheme

4. Details of participant.

   - Characteristics of participants are the Myanmar migrant workers aged 18 years and above, male and female, registered and unregistered, from different backgrounds and ethnic group of Burmese, Karen, Mon,

Rakhine, Shan, etc. who lives in Bang Khun Tien district, Bangkok Metropolitan area, Thailand

- Number of participants will be 400 participants

Inclusion criteria

- Myanmar migrant workers (male and female, registered and unregistered)
- Age 18 years and above
- Who can speak Burmese Language though they are not Burmese ethnicity
- Who are willing to participate in the research

Exclusion criteria

- Myanmar migrant workers who have difficulty in communicating in Burmese
- Who are temporary stay in Bang KhunThien (migrant workers who do not live in Bang Khun Thien)
- Who are working as volunteer at community based NGO team

5. The researcher and her assistant will explain to you about the purpose of the study and you can ask any questions that you want to know. All the information about questionnaire (social demographic factors, working condition, medical conditions, accessibility, perception and usage of insurance scheme) will be given before the interview so that you can decide whether you want to participate or not.

6. The face to face interview will be done by researcher herself and the assistant researchers, who are volunteers working in community based NGO. They already have training for conducting face to face interview by the researcher before the study. Interview will have 35 questions about 45 minutes and all recoded data will be deleted after the project.

7. Results of the study will be reported as total picture. Any of personal information which could be used to identify you will not appear in the report and will be kept confidential.

8. If it is shown that you do not meet the criteria of after screening process, your responses for this study cannot be used unfortunately. If you need any information, please do not hesitate to ask the researcher anytime.

9. The questions included are about socio-demographic information, medical conditions, working conditions, accessibility to health care services, perception towards health services, ownership of compulsory migrant health insurance card and usage of compulsory migrant health insurance card.

10. By answering these questions, we will guarantee you that you won't be either harm or socially disrupted. Your participation to the study is **voluntary** and you have the **right to deny** and/or **withdraw** from the study at any time without giving any reason.

11. The benefit of this study is that it will give baseline data on perception and usage of Compulsory Migrant Health Insurance Scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand. And it is expected that findings will be useful for the review and planning of better health care services system in the future.

12. The respondent will receive a token of appreciation (e.g. a bar of soap or a cleaning product) in return for their time.

13. If you have any question or would like to obtain more information, the researcher can be reached at all time. If the researcher has new information regarding benefit or risk/harm, participants will be informed as soon as possible.

14. If researcher does not perform upon participants as indicated in the information, the participants can report the incident to the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4th Floor, Soi Chulalongkorn 62, Phyathai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th.

Thank you very much for your kind cooperation.

……

(Ms.Hnin Oo Mon)
Principal investigator

APPENDIX D

Form of Participant Information Sheet for in-depth interview

Title of research project "PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND"

Principle researcher's name Hnin Oo Mon
Position Master of Public Health Student

Home address 55/145, New Panasin Place, 24/3 Ramkhamheng, Huamark, Bangkapi, Bangkok, Thailand, 10240

Cell phone +66(0)813037033

E-mail: hnin88@gmail.com

15. You are being invited to take part in a research project. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and do not hesitate to ask if anything is unclear or if you would like more information.

16. This research project involves "perception and usage of compulsory migrant health insurance scheme among adult Myanmar migrant workers in Bang Khun Thian District, Bangkok Metropolitan area, Thailand"

17. Objective (s) of the project are;

    - To study and explore the perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand
    - To find out the association of the socio-demographic characteristics, working conditions , medical condition, accessibility, health information and perception with the usage of compulsory migrant health insurance scheme

18. Details of participant.

    - Characteristics of participants are the Myanmar migrant workers aged 18 years and above, male and female, registered and unregistered, from different backgrounds and ethnic group of Burmese, Karen, Mon,

Rakhine, Shan, etc. who lives in Bang Khun Tien district, Bangkok Metropolitan area, Thailand

- Number of participants will be 6 participants

Inclusion criteria

- Myanmar migrant workers (male and female, registered and unregistered)
- Age 18 years and above
- Who can speak Burmese Language though they are not Burmese ethnicity
- Who are willing to participate in the research

Exclusion criteria

- Myanmar migrant workers who have difficulty in communicating in Burmese
- Who are temporary stay in Bang KhunThien (migrant workers who do not live in Bang Khun Thien)
- Who are working as volunteer at community based NGO team

19. The researcher will explain to you about the purpose of the study and you can ask any questions that you want to know. All the information about in-depth interview will be given before the interview so that you can decide whether you want to participate or not.

20. The in-depth interview will be done by researcher herself. In-depth interview will take about 45 minute. It will be recorded with mobile phone voice recorder and all information will be deleted at the end of the research.

21. Results of the study will be reported as total picture. Any of personal information which could be used to identify you will not appear in the report and will be kept confidential.

22. If it is shown that you do not meet the criteria of after screening process, your responses for this study cannot be used unfortunately. If you need any information, please do not hesitate to ask the researcher anytime.

23. The questions included are about Thai health care services, compulsory migrant health insurance, services in CMHI, barriers towards health services system, opinions, recommendations.

24. By answering these questions, we will guarantee you that you won't be either harm or socially disrupted. Your participation to the study is **voluntary** and you

have the **right to deny** and/or **withdraw** from the study at any time without giving any reason.

25. The benefit of this study is that it will give baseline data on perception and usage of Compulsory migrant health insurance Scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand. And it is expected that findings will be useful for the review and planning of better health care services system in the future

26. The respondent will receive a token of appreciation (e.g. a bar of soap or a cleaning product) in return for their time.

27. If you have any question or would like to obtain more information, the researcher can be reached at all time. If the researcher has new information regarding benefit or risk/harm, participants will be informed as soon as possible.

28. If researcher does not perform upon participants as indicated in the information, the participants can report the incident to the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4th Floor, Soi Chulalongkorn 62, Phyathai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th.

Thank you very much for your kind cooperation.

…….
(Ms.Hnin Oo Mon)
Principal investigator

APPENDIX E

Informed Consent Form for questionnaire

Address……
Date……..

Code number of participant ……

I who have signed here below agree to participate in this research project **Title** "PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND"

Principle researcher's name: HNIN OO MON

Contact address: 55/145, New Panasin Place, 24/3 Ramkhamheng, Huamark, Bangkapi, Bangkok 10240

Telephone: +66(0)813037033

I have **read or been informed** about rationale and objective(s) of the project, what I will be engaged with in details, risk/ham and benefit of this project. The researcher has explained to me and I **clearly understand with satisfaction.**

I willingly **agree** to participate in this project and consent the researcher to be interviewed for the in-depth interview. The interview time will be about 45 minutes.

I have **the right** to withdraw from this research project at any time as I wish with no need to **give any reason**. This withdrawal **will not have any negative impact upon me.**

The questions included are socio-demographic information, medical conditions, working conditions, accessibility to health care services, perception towards health services, ownership of compulsory migrant health insurance card and usage of compulsory migrant health insurance card.

Researcher has guaranteed that procedure(s) acted upon me would be exactly the same as indicated in the information. Any of my personal information will be **kept confidential.** Results of the study will be reported as total picture. Any of personal information which could be used to identify me will not appear in the report.

If I am not treated as indicated in the information sheet, I can report to the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4 Floor, Soi Chulalongkorn 62, Phyat hai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th,

I also have received a copy of information sheet and informed consent form

Sign ……..……
(……..……)
Researcher

Sign ……..……
(……..……)
Participant

Sign ……..……
(……..……)
Witness

APPENDIX F

Informed Consent Form for in-depth interview

Address ……
Date ……..

Code number of participant ……

I who have signed here below agree to participate in this research project

Title "PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND"

Principle researcher's name: HNIN OO MON

Contact address: 55/145, New Panasin Place, 24/3 Ramkhamheng, Huamark, Bangkapi, Bangkok 10240

Telephone: +66(0)813037033

I have **read or been informed** about rationale and objective(s) of the project, what I will be engaged with in details, risk/ham and benefit of this project. The researcher has explained to me and I **clearly understand with satisfaction.**

I willingly **agree** to participate in this project and consent the researcher to be interviewed for the in-depth interview. The interview time will be about 45 minutes.

I have **the right** to withdraw from this research project at any time as I wish with no need to **give any reason**. This withdrawal **will not have any negative impact upon me.**

The questions included are related to Thai health care services, compulsory migrant health insurance, services in CMHI, barriers towards health services system, opinions, recommendations.

Researcher has guaranteed that procedure(s) acted upon me would be exactly the same as indicated in the information. Any of my personal information will be **kept confidential.** Results of the study will be reported as total picture. Any of personal information which could be used to identify me will not appear in the report.

If I am not treated as indicated in the information sheet, I can report to the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4 Floor, Soi Chulalongkorn 62, Phyat hai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th,

I also have received a copy of information sheet and informed consent form

Sign ……..……
(……..……)
Researcher

Sign ……..……
(……..……)
Participant

Sign ……..……
(……..……)
Witness

APPENDIX G

Questionnaire for quantitative study

Questionnaire on Perception and usage of compulsory migrant health insurance scheme among adult Myanmar Migrant Workers in Bang Khun Thian district, Bangkok Metropolitan area, Thailand

Subject code _____	1☐☐☐
Interviewer code _____	2☐☐
Area _____	3☐
Date ……/……./……. **(A) Socio demographic characteristics** **1. How old are you?** **_____Years**	4☐☐
2. What is your gender? (1) [ ] Male (2) [ ] female	5☐
3. What is your ethnicity? (1) [ ] Burmese (2) [ ] Karen (3) [ ] Mon (4) [ ] Rakhine (5) [ ] Shan (6) [ ] others (please specify) _____	6☐

4. What is your marital status? (1) [ ] Single (4) [ ] Widowed (2) [ ] Married (5) [ ] Cohabit (3) [ ] Divorced/separated	7 ☐
5. How many persons live in the same house with you? _____ (persons)	8 ☐☐
6. What is your average monthly income? _____ Thai Baht	9 ☐
7. What is your occupation? (1) Factory worker [ ] (2) Construction worker [ ] (3) Unemployed/Dependent [ ] (4) Others ————————————	10 ☐
8. How long have you been staying in Thailand? _____(months)_____ (years)	11 ☐☐

9. What about your Thai language skills? (1) [ ] Cannot speak at all (2) [ ] Can speak basically (3) [ ] Can speak Thai language fluently but cannot read and write (4) [ ] Fluent in Thai language / can read and write	12 ☐
10. What is your education achievement? (1) [ ] Never go to school (2) [ ] Primary school (3) [ ] Middle school (4) [ ] High school (5) [ ] Higher education (6) [ ] others	13 ☐
(B) Medical conditions **11. Do you have any diseases diagnosed by medical staff?** Don't know [ ] Yes [ ] No [ ]	14 ☐
12. Did you have any illness during last 6 months? Don't know [ ] Yes [ ] No [ ]	15 ☐
If yes, what illness did you have? _____	

(C) Working conditions **13. What about your registration status?** (1) [ ] Registered (2) [ ] Unregistered	16 ☐
14. How many job you changed before this current job? _____(numbers)	17 ☐☐
15. How long have you been working in this current job? _____ (months) _____ (years) **16. How long do you work per days? ____ (hours)** **17. How many days do you work in a week? ____ (days)**	18 ☐☐
(D) Accessibility **18. Have you ever been to hospital?** Yes [ ] No [ ]	19 ☐
19. If yes on no.18, did you go for yourself or your friend or family? Myself [ ] Friend/Family [ ]	20 ☐
20. How long would it take you to get to health center from your home? _____ (minutes) _____ (hours) [ ] Don't know	21 ☐
21. Is the travelling cost expensive for you? (1) [ ] Yes (2) [ ] No (3) [ ] Don't know	22 ☐

22. Where or from whom did you receive the information about health services? (1) Friends [ ] (2) Family [ ] (3) Workplace [ ] (4) Community [ ] (5) Volunteer [ ] (6) Social media [ ] (7) Don't know [ ]	23 ☐
23. Is doctors' fee expensive for you? (1) [ ] Yes (2) [ ] No (3) [ ] Don't know	24 ☐
24. How long do you have to wait to see physician at health center? _____ (minutes) _____ (hours) [ ] Don't know	25 ☐
25. Which language is used at the hospital or health center? (1) [ ] Thai (2) [ ] English (3) [ ] Burmese (4) [ ] Don't know	26 ☐
26. Does the hospital/health center provide you with translator? (1) [ ] Yes (2) [ ] No (3) [ ] Don't know	27 ☐
27. Are you satisfied with health services in health center? (1) [ ] Yes (2) [ ] No (3) [ ] Don't know **(E) Perception towards health services (7 Statements)**	28 ☐
28. Health services provided at the hospital are sufficient for the migrant health problems Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	29 ☐

29. The service providers in the hospital are kind and helpful to the migrant workers Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	30 ☐
30. Hospital card is useful and essential for everyone. Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	31 ☐
31. Hospital card is not expensive for the migrant Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	32 ☐
32. I can understand the explanation of the doctor and nurses. Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	33 ☐
33. An interpreter is needed for the translation of the language. Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	34 ☐
34. You are satisfied with the health services provided in the hospital Strongly disagree [ ] Disagree [ ] Uncertain [ ] Agree [ ] Strongly agree [ ]	35 ☐
Total score	36 ☐☐
35. Do you own CMHI card now or not? (1) [ ] Yes (2) [ ] No	37 ☐
36. If do not own now, Have you owned CMHI card before or not? (1) [ ] Yes (2) [ ] No	38 ☐

37. If you own CMHI, who buy it for you? (1) [ ] By myself (2) [ ] By my employer (3) [ ] By my family (4) [ ] By my friend	39 ☐
38. Usage of CMHI (1) [ ] Never (2) ------- times less than 6 months (3) ------- times more than 6 months	40 ☐

APPENDIX H

Qualitative study plan

1. Introduction by researcher and explanation of research process to the respondent
   Components: Thank you, name of respondent, Purpose, confidentiality, time of interview
2. Any question regarding the process?
3. Informed consent

Pre-planned question set

Please describe about the health services offered by the Thai Government to Myanmar Migrant Workers.

What type of insurance a migrant worker can have in Thailand?

What services are included in CMHI scheme?

What services are excluded in CMHI scheme?

What are the barriers towards using this service?

How did you overcome the barrier(s)?

What is your opinion towards health services system?

What recommendation do you have for progress?

Verify the information from the respondent to receive clarity on the information (during interview as necessary)

Probes questions should be used as needed.

Can you elaborate on that idea?

Would you explain further?

Is that anything else?

I'm not sure I understand what you are saying. Can you explain a bit more?

Would you give me an example?

Closing session:

Is there any information you would like to add more for this issue?

Say "Thank you for your time".

APPENDIX I

Ethical Approval Form

AF 02-12

The Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University
Institute Building 2, 4 Floor, Soi Chulalongkorn 62, Phyat hai Rd., Bangkok 10330, Thailand.
Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th

COA No. 068/2015

Certificate of Approval

Study Title No.027.1/58 : **PERCEPTION AND USAGE OF COMPULSORY MIGRANT HEALTH INSURANCE SCHEME AMONG ADULT MYANMAR MIGRANT WORKERS IN BANG KHUN THIAN DISTRICT, BANGKOK METROPOLITAN AREA, THAILAND**

Principal Investigator : MISS HNIN OO MON

Place of Proposed Study/Institution : College of Public Health Sciences, Chulalongkorn University

The Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University, Thailand, has approved constituted in accordance with the International Conference on Harmonization – Good Clinical Practice (ICH-GCP) and/or Code of Conduct in Animal Use of NRCT version 2000.

Signature: ..... Signature: .....

(Associate Professor Prida Tasanapradit, M.D.) (Assistant Professor Nuntaree Chaichanawongsaroj, Ph.D.)

Chairman Secretary

Date of Approval : 1 April 2015 Approval Expire date : 31 March 2016

The approval documents including

1) Research proposal
2) Patient/Participant Information Sheet and Informed Consent Form
3) Researcher
4) Questionnaire

Protocol No. 027.1/58
Date of Approval - 1 APR 2015
Approval Expire Date 31 MAR 2016

The approved investigator must comply with the following conditions:

1. *The research/project activities must end on the approval expired date of the Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University (ECCU). In case the research/project is unable to complete within that date, the project extension can be applied one month prior to the ECCU approval expired date.*
2. *Strictly conduct the research/project activities as written in the proposal.*
3. *Using only the documents that bearing the ECCU's seal of approval with the subjects/volunteers (including subject information sheet, consent form, invitation letter for project/research participation (if available).*
4. *Report to the ECCU for any serious adverse events within 5 working days*
5. *Report to the ECCU for any change of the research/project activities prior to conduct the activities.*
6. *Final report (AF 03-12) and abstract is required for a one year (or less) research/project and report within 30 days after the completion of the research/project. For thesis, abstract is required and report within 30 days after the completion of the research/project.*
7. *Annual progress report is needed for a two- year (or more) research/project and submit the progress report before the expire date of certificate. After the completion of the research/project processes as No. 6.*

VITA

Name: Mrs.Hnin Oo Mon

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Place of birth: Lashio, Northen Shan State, Myanmar

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Educational achievement:

- M.B., B.S (2011) from University of Medicine (1), Yangon, Myanmar

Working experience

- Medical correspondence, Physician for referral center in Bangkok International Hospital

- Volunteer/ Coordinator in Migrant health projects in Path2Health foundation