Health Communication Issues among Migrant Workers in Thailand: A Systematic Review for Health Communication Practices
ประเด็นการสื่อสารสุขภาพในแรงงานต่างด้าวในประเทศไทย: การทบทวนเอกสารอย่างเป็นระบบเพื่อแนวทางปฏิบัติด้านการสื่อสารสุขภาพ

Patama Satawedin[1]

Abstract

Migration moving from neighboring countries provides economic contribution and development to both migrant workers *per se* and a nation as a whole. In Thailand, a number of migrant workers are large, especially those who are from Myanmar, Lao People's Democratic Republic, and Cambodia, and that could indicate high prevalence of communicable and non-communicable disease widespread in a country they wish to seek for job opportunities. The objective of this study was to systematically review the importance of health communication issues among migrant workers in Thailand and later on to give practical applications for health communicators and healthcare service providers. Articles available on Bangkok University database and relating to migrant workers in Thailand were selected. So, out of 281 search results, 15 papers met the requirements. The results indicated that the majority of the papers were triggered to Burmese migrant workers, while none aimed at exploring Laotian and Cambodian migrant workers. Two exceptions were found, though: one paid attention to Thai, Cambodian, and Burmese migrant workers and the other focused on migrant workers from Thailand, Vietnam, Lao, and Cambodia. Further to this, the selected studies were mostly primary research using the quantitative approach. Likewise, the majority of them prioritised the necessity of tuberculosis, HIV/AIDS, and human trafficking. In addition to these, the migrant workers in Thailand were somewhat facing unhealthy and deteriorating conditions due to demographic, personal and environmental factors. Recommendations for health communication practices were discussed.

Keywords: *Health Communication, Migrant Workers, Thailand, Systematic Review*

[1] Public Relations Department, School of Communication Arts, Bangkok University, E-mail: patama.s@bu.ac.th

บทคัดย่อ

การอพยพย้ายถิ่นฐานก่อให้เกิดประโยชน์และการพัฒนาด้านเศรษฐกิจของทั้งแรงงานต่างด้าวเองและประเทศชาติโดยภาพรวม แรงงานต่างด้าวในประเทศไทยมีจำนวนมาก โดยเฉพาะอย่างยิ่งแรงงานต่างด้าวที่มาจากประเทศเมียนมาร์ ลาว และกัมพูชา ซึ่งนั่นสามารถบ่งบอกได้ถึงการแพร่กระจายของโรคติดต่อและไม่ติดต่อที่เกิดขึ้นในประเทศที่แรงงานต่างด้าวดังกล่าวต้องการจะย้ายถิ่นเพื่อไปทำงาน การวิจัยชิ้นนี้มีวัตถุประสงค์เพื่อศึกษาถึงการให้ความสำคัญกับประเด็นการสื่อสารสุขภาพในกลุ่มแรงงานต่างด้าวในประเทศไทยอย่างเป็นระบบ และนำเสนอแนวทางการปฏิบัติด้านการสื่อสารสุขภาพให้กับผู้ที่ทำงานด้านการสื่อสารสุขภาพและผู้ให้บริการด้านสุขภาพ โดยใช้บทความในฐานข้อมูลของมหาวิทยาลัยกรุงเทพ และเลือกผลงานที่ศึกษาเฉพาะแรงงานต่างด้าวในประเทศไทย ดังนั้น จากผลการค้นหาทั้งสิ้น 281 ผลลัพธ์ พบบทความที่เป็นไปตามข้อกำหนดเพียง 15 บทความเท่านั้น ผลการวิจัยพบว่าการศึกษาส่วนใหญ่มุ่งศึกษาแรงงานต่างด้าวชาวพม่า และไม่มีการศึกษาใดที่สนใจศึกษาแรงงานต่างด้าวชาวลาว และกัมพูชาเลย ยกเว้นการศึกษาหนึ่งที่ศึกษาภาพรวมของแรงงานต่างด้าวชาวไทย กัมพูชา และเมียนมาร์ ในขณะที่อีกการศึกษาหนึ่งมุ่งให้ความสนใจไปที่แรงงานต่างด้าวจากประเทศไทย เวียดนาม ลาว และกัมพูชา ในขณะเดียวกันการศึกษาส่วนใหญ่ใช้การศึกษาปฐมภูมิ และใช้วิธีการวิจัยเชิงปริมาณ ประเด็นด้านการสื่อสารสุขภาพที่พบบ่อยมากที่สุด คือ วัณโรค เอชไอวี/เอดส์ และการค้ามนุษย์ นอกจากนั้น การที่แรงงานต่างด้าวเผชิญกับปัญหาด้านสุขภาพเกิดขึ้นทั้งจากปัจจัยส่วนบุคคล และปัจจัยภายนอก โดยมีการเสนอแนะถึงแนวทางการปฏิบัติด้านการสื่อสารสุขภาพกัน

คำสำคัญ: *การสื่อสารสุขภาพ แรงงานต่างด้าว ประเทศไทย การทบทวนเอกสารอย่างเป็นระบบ*

Introduction

Migration - moving from neighboring countries provides economic opportunities and wealth to not only workers (Chimmamee, 2015; Davis & Brazil, 2016; Jiang, 2016; Mishra & Gillespie 2016; Nanthavong, 2013), but also a host nation (Martin, 2007; Nodera, 2001; Pholphirul & Rukumnuyakit, 2008; Torres & Carte, 2016). The study of Chantavanich and Vungsiriphaisal (2012) apparently underlined prosperous future of migrant workers that '[t]hese migrants contribute millions baht of their remittent annually to support their families in Myanmar in addition to and have obtained valuable skills and experiences from working in Thailand. Some of Myanmar migrant workers plan to go back in a few years ...'

Apart from Malaysia, in Southeast Asia, Thailand is the country that has attracted a larger number of legal or documented and illegal or undocumented migrant workers, according to the statistical report of the United Nations (Kirk, 2016), especially those from Myanmar, Lao People's Democratic Republic, and Cambodia during the past decade (Social and Quality of Life Database System, 2014; Unicef, 2014). Currently, there have been approximately 3.7 million migrant workers in Thailand (Social and Quality of Life Database System, 2014; Unicef, 2014). The most importantvariableresults from escapes from worse economic status (Chaisuparakul, 2015; Pripotjanart, 2015; Shafique et al., 2016; Walsh & Ty, 2011). The studies of Walsh and Ty (2011) and Chaisuparakul (2015), likewise, confirmed a big difference in daily allowance, i.e. compared to Cambodia's, that in Thailand has doubled to tripled. Further to this factor, there are

environmental disasters / atmospheric conditions (Cattaneo & Peri, 2016; Walsh & Ty, 2011), political and economic transition (Chantavanich & Vungsiriphisal, 2012; Peou, 2016; Pripotjanart, 2015), holidays (Pripotjanart, 2015), and no diversities in ways of life and language use (Pripotjanart, 2015) thriving on migration from the neighboring countries to Thailand. An interview from Dr Scythia Muang can clearly explain their sufferings from the reforms in political and economic factors that "I and my colleagues fled through the jungle to Thailand to escape persecution" (Win, 2016).

Following to this, however, almost all of the data reviewed and observed also confirmed unhealthy, unclean, uncomfortable, and easy-to-build living conditions of migrant workers (e.g., Hugo, 2003; Tharathep, 2011). That is to say, these lower-skilled workers were challenged by living and working in dirty, dangerous, and demanding conditions, or, in short "3D jobs" (Natali, McDougall, & Stubbington, 2014). The statement of Jeff Labovitz, chief of mission in Thailand for the International Organization for Migration (IOM) was cited as, "[m]igrantlabourers are now working in areas where Thais no longer wish to work" (AFP, 2015). By referring to MAP (2010), Pripotjanart (2015), conclusively, makes clear image how migrant workers are living: '..., migrant working in factories are housed in barracks within the factor compound, migrants on construction sites live in shanty dwellings on site, domestic workers live in the houses of their employers, agricultural workers build small bamboo in the orchards or tin huts in the rubber plantations. Only a small minority of workers lives independently of their employer'. Also, the study of Chaisuparakul (2015) disclosed that:

> 'Their [Cambodian migrant workers] days mostly center around work, starting at 6 a.m. when they wake up and eat breakfast, which the married migrant workers usually prepare by themselves as a couple. Single migrant workers typically buy meals. In some work situations, migrant workers can return home for the noon meal. All of the migrant workers interviewed seek overtime work opportunities to accumulate more income. When they return home, there is just enough time for the evening meal before bedtime. On days off, the migrant workers said they stay at home and watch TV or listen to music. On pay days (usually every two weeks), male migrant workers tend to drink alcohol with their peers, while the female migrant workers prefer to go to the local temple to make merit. Despite these diversions, all the migrant workers seemed scrupulous about the need to save money and only spend on necessities. If they buy household items, they often choose second-hand goods in order to be frugal. ... One employer of migrant workers observed that the single or younger migrant workers seem to be attracted to the latest fashions and electronics, such as mobile phones. Accordingly, they are less frugal and remit less money back to Cambodia'.

As a consequence of this, health issue, the odds of both communicable and non-communicable diseases is of high concern and importance (Abu-Madi et al., 2016; Baker, 2011). The World Health Organization (2016) addressed that '[t]he most frequent health problems of

newly arrived refugees and migrants include accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy – and delivery-related complications, diabetes and hypertension. Female refugees and migrants frequently face specific challenges, particularly in maternal, newborn and child health, sexual and reproductive health, and violence. The exposure of refugees and migrants to the risks associated with population movements – psychosocial disorders, reproductive health problems, higher newborn mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence – increase their vulnerability to non communicable diseases (NCDs). The key issue with regard to NCDs is the interruption of care, due either to lack of access or to the decimation of health care systems and providers; displacement results in interruption of the continuous treatment that is crucial for chronic conditions'. Baker, Holumyong, & Thianlai (2010); and Baker (2011) also underlined that post to migrating to Thailand, having worse health status is found among migrant workers than Thai residents. On their arrivals, altogether, the spreads of malaria, diarrhea, HIV/AIDS, polio, anthrax, and the like are uncovered (Ekkajumpaka & Watthanamano, 2011). Also, from the study of Tangena, Thammavong, Wilson, Brey, & Lindsay (2016) and Durnez et al. (2013, as cited in Canavatiet al., 2016), malaria is likely to be most found among migrant workers. Sadly, nonetheless, illegal and undocumented migration keeps migrant workers from possible health care services provided by local authorities. As Fletcher and colleagues said that '[i]n Thailand, Burmese migrant workers were reluctant to seek out assistance, due to their experiences of discrimination and for fear of arrest based on their immigration status' (Lewis & Maguire, 2016). This happens not only in Thailand, but also around the globe including Bangladesh (Kamal, Curtis, Hasan, & Jamil, 2016).

It seems that these migrant workers *per se* are perceived themselves and/or treated by others as "the vulnerable", i.e. others' helps are of need. It would be the other way round if these migrant workers are given and shared correct communication and understanding to promote their own health status so that they can live happily and sustainably. It is vital for any parties concerned in providing migrant workers communication and information so that they are aware of caring their own health (Tharathep, 2011). He further complained that current failure is because of lack of exchanging information (Tharathep, 2011).

The objective of this study, therefore, was to systematically review the importance of health issues among migrant workers in Thailand. When saying health issues, these covered the following health categories, i.e. 'behavioral health,' 'cancer,' 'children's health,' 'diabetes,' 'eye care,' 'family violence,' 'HIV/AIDs,' 'Hepatitis,' 'Immunizations,' 'oral health,' 'tuberculosis,' 'women's health' (Migrant Clinicians Network, 2016). The study also aimed to give health communication applications for health communicators and healthcare service providers.

Objectives

1. To systematically review the importance of health communication issues among migrant workers in Thailand.

2. To give health communication applications for health communicators and healthcare service providers.

Methodology

Throughout Bangkok University database, academic articles containing two keywords, i.e. 'migrant workers' and 'in Thailand' were searched and used and the search was limited to year 2016 only (from 1 January to 17 September 2016). Also, the ones reporting migrant workers in Thailand were selected and cascaded only. It was important to mention at this point that, there is no differentiation between migrant workers and refugees. So, out of 281 search results (dated on 17 September 2016), 15 papers met the requirements.

Findings

Target Audiences

According to the greatest deal of migrant workers in Thailand, the majority of the papers were triggered to Burmese migrant workers, followed by the ones that indicated no nationalities of migrant workers. There was only one each for Thai policy makers and for the necessity of Thai, Vietnamese, Laotian, and Cambodian migrant workers. No academic scholars, however, focused their interests on studying Cambodian and Laotian migrant workers, in particular. In general, foreign workers living in Thailand were mostly studied. The details of such findings were exhibited in Table 1.

Table 1 Nationality of the Studies' Target Audiences

Nationality	Literature
Burmese migrant workers	Banks et al. (2016); Höglund et al. (2016); Howes & Hammett (2016); Murray, DiStefano, Yang, & Wood, (2016); Musumari & Chamchan (2016); Salisbury et al. (2016); Tschirhart, Sein, Nosten, & Foster (2016); Tschirhart, Nosten, & Foster (2016b).
Not specify	Chandoevwit et al., (2016); Lyttleton (2016); Pengpid et al. (2016); Phares et al. (2016)
Thai policy	Marschke & Vandergeest (2016)
Thai, Cambodian, & Burmese migrant workers	Chantavanich, Laodumrongchai, & Stringer (2016)
Migration from Thailand, Vietnam, Lao, & Cambodia	Hübler (2016)

Research Methods Used

Simply divided into primary and secondary data and quantitative and qualitative research methods, the majority of the studies employed primary and quantitative research. However, one mixed-method study was found. No indication could be made for two studies because they focused on laboratory tests of hepatitis and blood. Table 2 gave a conclusive idea.

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Table 3 Health Issued Addressed in the Studies (continued)

Issue Addressed	Literature
Family planning	Salisbury et al. (2016)
Maternal mortality	Chandoevwit et al. (2016)
Hepatitis B	Banks et al. (2016)
Plasmodium vivax infection	Höglund et al. (2016)
Human trafficking	Chantavanich et al. (2016); Marschke & Vandergeest (2016)
Emotional citizenship	Howes & Hammett (2016)
Mobile phones technology diffusion	Hübler (2016)

From the studies, ranging from demographic, personal to environmental considerations were causes of the short of healthiness and well being among the migrant workers in Thailand. As for demographic, personal issues, these could include age, family's health status and medical conditions, individual behavior, and language deficits. The environmental factors, likewise, could cover lack of publicity (i.e. message distribution and media outreach and limited media devices for building knowledge, attitudes, and practices); health communicators and healthcare service providers (i.e., communication skills, lack of supporting and available medicines and services for the migrant workers, especially not too expensive ones, lack of keeping their health record and history, lack of having healthcare service providers giving the migrant workers social, cultural, mental, and environmental understanding); lack of appropriate, good migration management (including illegal recruitment and working conditions); and disparity in cultures.

Practical Recommendations for Health Communicators

Even in different health-related contexts and further to the variables discovered above, generally speaking, it was recommended, especially for health communicators and healthcare service providers, to implement in practice that:

One: Conveying simple, easy-digestible, touchable, tailored-made, and catchy messages.

Two: Repeating them all over again and again.

Three: Giving them via omni channels, especially face-to-face, interpersonal communication

Four: Cultivating empathic communication.

Five: Doing what healthcare service providers have said

Six: Customizing communication to different, original cultural backgrounds

Discussion and Conclusions

According to the findings, the sampled studies paid their most concern to Burmese migrant workers. Nonetheless, Laotian and Cambodian migrant workers were not solely

examined. There were the exceptions of only one study paying attention to Thai, Cambodian, and Burmese migrant workers and another study focusing their interest in migrant workers from Thailand, Vietnam, Lao, and Cambodia. Most of the researchers fell in love with collecting the data by themselves, i.e. primary research and by quantitative research. This paper might be against the claim that malaria was of high disease mostly found in the migrant workers (Durnez et al, 2013, as cited in Canavati et al., 2016); Ekkajumpaka & Watthanamano, 2011; Tangenaet al., 2016) because a higher number of the sampled studies went to tuberculosis, HIV/AIDS, and human trafficking, respectively. The World Health Organization (2014) consistently revealed that HIV/AIDS and tuberculosis were the two diseases, out of ten, causing death around the globe, though.

In addition to these, the migrant workers in Thailand were somewhat facing unhealthy and unwell conditions because of demographic, personal and environmental factors. The migrant workers' age, family health status and medical conditions, individual behaviour, and language barrier were the demographic, personal discouraging factors. Limited publicity, health communicators and healthcare service providers, inappropriate, unwell migration management, and cultural dissimilarities could externally cause unhealthy and unwell conditions among the migrant workers.

Even though '[t]here is no single 'right way' to ensure effective communication with (and among) a migrant workforce,' said Jeremy Bevan (British Safety Council, 2014), to uplift the restricted communication with migrant workers, consequently, this paper suggested the six important communication strategies for health communicators and healthcare service providers. These included the giving's of (1) simple, easy-digestible, touchable, tailored-made, and catchy messages, (2) of message repetition, (3) of multi-channels, especially face-to-face, interpersonal communication (4) of empathic communication, (5) of actual implementation, and (6) of culturally different concern.

How well and efficient healthcare services were indicated by level of language proficiency (Manaluz-Torres, 2015). As Manthorpe, Hussein, & Stevens (2012) found, migrant workers were unable to understand and reach the content because of their limited language ability. It was, therefore, important for health communicators and healthcare service providers to provide them easy-to-understand messages (British Safety Council, 2014). Likewise, all communication channels should be employed, ranging from the richer medium like interpersonal communication to the leaner mass communication. Especially, the former one was more likely to be effective when the study of Lo (2014) revealed the effectiveness of self-disclosed and dynamic, two-way communication. Later on, knowledge and information could be, later on, diffused to migrant workers' friends and acquaintances when exploiting interpersonal communication (Frantz, 2014). Particularly, the migrant workers who were good command in two languages could enhance better health understanding and practices and help closing cultural gaps among migrant workers *per se* (Lee, Sulaiman-Hill, & Thompson, 2014). In contrast, digital and mass communication could not be underestimated since some of the migrant workers had their own mobile phones and had skills on using them (Frantz, 2014; Manaluz-Torres, 2015).

Putting yourself in others' shoes, empathic communication could not be avoided nowadays because '*[e]xtensive research has shown that no matter how knowledgeable a clinician might be, if he or she is not able to open good communication with the patient, he or she may be of no help*' (Institute for Healthcare Communication, 2011).

Migrant workers would like to balance between otherness and 'I' ness (Chen, 2008), hence, it would not be strange for health communicators and healthcare service providers to not only know yourself, i.e, their own culture and regulations and cultural adaptation, but also know others, i.e. migrant workers' backgrounds.

To reach for the Sun, the contribution of this study was, therefore, to make all parties concerned from policy-making (i.e., health policy makers and administrators to professional levels (i.e., healthcare professionals) re-thought on and bridge such recommended gaps.

For this study, the limitation fell only into the availability of databases Bangkok University whose permission was given to access. In other words, more or less academic and research papers meeting the requirements can be found if access via other universities was allowed. Future studies should beconsideredto design and develop a mock-up communication model and validate with a sampled migrant workers.

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Appendix

The 15 papers that were included in this paper were as follows:

1. Musumari, P.M. & Chamchan, C. (2016). Correlates of HIV testing experience among migrant workers from Myanmar residing in Thailand: A secondary data analysis. *PLoS ONE, 11*(5): 1-19. doi: 10.1371/journal.pone.0154669

2. Chantavanich, S., Laodumrongchai, S., & Stringer, C. (2016). Under the shadow: Forced labour among sea fishers in Thailand. *Marine Policy, 68*, 1-7. doi: http://dx.doi.org/10.1016/j.marpol.2015.12.015

3. Marschke, M. & Vandergeest, P. (2016). Slavery scandals: Unpacking labour challenges and policy responses within the off-shore fisheries sector. *Marine Policy, 68,* 39-45. doi: http://dx.doi.org/10.1016/j.marpol.2016.02.009

4. Murray, J.K., DiStefano, A.S., Yang, J.S., & Wood, M.M. (2016). Displacement and HIV: Factors influencing antiretroviral therapy use by ethnic Shan migrants in Northern Thailand. *Journal of the Association of Nurses in AIDS Care, 27*(5), 709-721. doi: 10.1016/j.jana.2016.04.006

5. Howes, L. & Hammett, D. (2016). Negotiating identities and emotional belonging: Shan in northern Thailand. *Emotion, Space and Society, 19*, 21-28. doi: http://dx.doi.org/10.1016/jemospa.2016.04.001

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11. Hübler, M. (2016). Does migration support technology diffusion in developing countries? *World Development, 83,* 148-162. doi: http://dx.doi.org/10.1016/j.worlddev.2016.01.024.

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