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ORIGINAL RESEARCH

Problems of Myanmar Women of Reproductive Age in Accessing Health Services as Migrant Workers in Thailand: A Qualitative Study

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Abstract

Background: The largest portion of migrant labor in Thailand originates from Myanmar, with almost half consisting of female workers. Most female migrant workers (MWs) are of reproductive age and often experience physical illnesses, including pregnancy and childbirth. Although access to prenatal care and delivery services for Myanmar MWs has been previously studied, their challenges in accessing other reproductive health services (HSs) have not yet been explored.
Purpose: This study aimed to explore problems in accessing health services experienced by women of reproductive age (WRA) who were members of the Myanmar migrant workforce in Thailand.
Methods: The present study employed a qualitative research design. The samples consisted of 20 informants aged 18-49 years old, who were Myanmar WRA working as migrant laborers for more than one year. They were subdivided into two groups: 10 participants provided information through in-depth interviews, and the other 10 participated in focus group discussions, with each group comprising 5 individuals. The researchers selected informants using criterion sampling. Data analysis utilized the Diekelmann and Allen method.
Results: The findings revealed two general themes, including care ineligibility and problems in accessing health services. The six major issues among Myanmar WRA include inability to purchase or renew health insurance cards (HICs), HIC or social security wage deduction avoidance, communication issues, hospital inexperience, the transit fare, and admission refusal.
Conclusion: Despite available health services, migrant women from Myanmar encounter barriers such as inability to purchase health insurance cards, wage deduction concerns, communication issues, hospital unfamiliarity, transportation expenses, and admission refusal. Addressing these barriers through policy interventions and support mechanisms is crucial for enhancing healthcare access.

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1. Introduction

Thailand is experiencing a sizeable migrant workforce entering the country as a consequence of its rapid economic expansion, resulting in demand for labor to keep it active (Ministry of Labor, 2021). Much of the migrant workforce is from Myanmar, Laos and Cambodia, while the majority of the migrant workers (MWs) are from Myanmar since many of them were fleeing the poverty of their home country (The World Bank, 2018). Many had clashed with the army of Myanmar and were thus forced to flee to Thailand as laborers (BBC News Thai, 2022). The provinces with the largest migrant workforce are the Bangkok Metropolis, its suburbs, and the major upcountry provinces (Foreign Workers Administration Office, 2021a). In December of 2020, the Bangkok Metropolis and its suburbs had a total migrant workforce of 1,023,287, and 735,881 of the workers were of Myanmar nationality (71.91%) (PPTV Online, 2020). Nearly one half of these workers were female (Foreign Workers Administration Office, 2021b).

A majority of the women in the migrant workforce are of reproductive age and were facing problems in their reproductive health, contraception planning, pregnancy and childbirth (Phetsaen & Haritavorn, 2019). When their bodies become fatigued from working, they consume an energizing beverage and use medication. In the event of minor illness, they simply purchase

medication which they take on their own, rest, and then return to their work (Sangsrijan et al., 2016). If their illness is serious, they seek care at a primary-care hospital (Vichanjalearnsuk & Chaimanee, 2015). In a study conducted by Phetsaen and Haritavorn (2019) that explored the situations of Myanmar MWs' access to prenatal care and delivery services, it was found that the social health determinants affecting service access of women in the migrant workforce from Myanmar included MW health policy, service system, transportation, income, the nature of the work and social support. Most of the obstacles consisted of language matters and communication (Phetsaen & Haritavorn, 2019).

Thai welfare provides care for its migrant workforce in the form of health insurance cards (HICs) and social security (SS) cards. The cost of preparing the HICs is roughly 129 US dollars; and for the SS cards, it is roughly 37 US dollars (Rajavithi Hospital, 2022). Both Thai nationals and foreigners can receive treatment services matching their health problems.

Women were known to have higher rates of illness than men. They had higher rates of disability, and their self-rated health was typically lower than that of men (Simons et al., 2023). Women were more likely than men to engage preventative health services (HSs), even when accounting for antenatal and reproductive HSs (Simons et al., 2023). It is the policy of Thailand to adjust the status of the migrant workforce lawfully so that the workforce can then enter the system and be on medical welfare. However, it was found that more than one half of the migrant workforce still had no access to medical welfare (Sritiang, 2021). The situations of Myanmar MWs' access to prenatal care and delivery services have been previously studied (Phetsaen & Haritavorn, 2019), however, their problems in accessing other reproductive HSs have not been explored. Therefore, the researchers wanted to learn about the issues that female Myanmar MWs had been facing in accessing reproductive HSs in order to understand why many refused to use the government's medical services and only seek treatment when seriously ill. Accordingly, this study was conducted to explore problems in accessing health services among women of reproductive age (WRA) who were members of the Myanmar migrant workforce in Thailand. The researchers were especially hopeful that the results of their study would serve as a foundation of policy-based decision making aimed at developing an HS system for the migrant workforce that would be both efficient and suitable.

2. Methods

2.1. Research design

The present study employed a qualitative research design with a Heideggerian hermeneutic phenomenology approach (Heidegger, 2019) to explore healthcare access issues among working women of childbearing age from Myanmar who migrated to Thailand as laborers.

2.2. Setting and participants

This study was conducted among Myanmar women of reproductive age residing in Thailand. The samples consisted of 20 informants, who were subdivided into 10 participants providing information through in-depth interviews and 10 participants participated in focus group discussions, with each group comprising 5 individuals.

In individual interviews, the first informant was selected based on the predetermined criteria. The researchers visited a fresh vegetable market in Pathum Thani, introduced themselves to some vendors, and asked for their suggestions. The Myanmar women were selected based on the criteria as follows: working as migrant laborers and were in the age range of 18-49 years. They had been working in Talaad Thai market, Pathum Thani, for more than one year. Once these informants agreed to take part in the research, the researchers used the snowball-sampling method to recruit other informants for the interviews to the point of information saturation, that is, when additional information did not contribute to new understanding. For the group discussions, the researchers scheduled the place, date, and time for the subjects selected according to their criteria.

2.3. Data collection

In this study, data collection was conducted for six months, from August 2022 to January 2023, before which the research team submitted a request for research permission to Talaad Thai authority. After that, the researchers carried out the data compilation. Upon meeting the key participants, the researchers began the investigation by introducing themselves and clarifying the

objectives of the study and the data collection method. Participants were given time to consult their families on whether to participate the next day. They took the subject information sheet and informed consent form home to read. On the second day, after the key participants signed their participation agreements, the principal investigators and the research assistants formed a relationship and a sense of familiarity with the people in the sample group. Once the key participants had become more familiar with the research, the in-depth interviews were conducted in the participant's home in a two-way communication format, which helped to foster a more direct understanding with factual meanings that the informants wanted to convey. Their emotions could be read from their facial expressions and demeanor. The result was more detailed information enabling a complete understanding of purpose and background. It became possible to delve into problems that were difficult or too sensitive to talk about. It fostered insight into the problems and made it possible to acknowledge the particular matters that the interview subjects were dealing with. It then became possible to test the validity of the information that had been supplied. Interviews continued for 45-60 minutes per session and were conducted in-line with the prepared questions.

During the interview, the investigators asked several questions (see Table 1) and made certain that the data from the key participants was accurate. This procedure allowed the key participants to elaborate on some points that were unclear. The nature of the interview was conversational and based on attentive listening without judgment. Interviewers encouraged the key participants to share their experiences. The assistants recorded and took field notes throughout the interview and made arrangements for an additional interview whenever some points were still unclear. Informants were interviewed twice. The next interview would take approximately 30 minutes. The interview continued until the investigators were fully satisfied. An examination of the information obtained indicated that the information just received was actually a duplicate, and that there was no new information. In addition, data were also collected via focus group discussions (FGDs) in order to draw conclusions from a large group of people's opinions. Each group consisted of 5 members, who participated in an FGD for 45-60 minutes, with the researchers leading the groups and the research assistants serving as observers and recorders. The participants were arranged in a circle to make it easier for them to express their opinions. The focus group method had the advantage that the participatory information obtained revealed a diversity of viewpoints, while the reactions of those taking part in the conversations were quite similar, resulting in in-depth information on those matters. For the informants who were willing to take part in the group conversations, a time and familiar setting were designated, free from disturbances such as from a temple or school.

Table 1. Question guidelines

List of Questions for the Participants
• When you are ill, what are your rights in receiving care?
• What experience do you have in making use of your rights to receive care?
• How do you feel about your rights to receive the care you now have?
• Where do you mostly get medical care?
• How do you feel about going to hospital?
• What are the barriers to receiving health services?

2.4. Data analysis

The first phase of data analysis involved compiling the data itself, which included attentive listening, reflecting, clarifying, and pondering. Transcripts of the audio recordings were prepared, and field notes were also recorded. All recorded data was then analyzed for its contents using the seven stages of data analysis proposed by Diekelmann et al. (1989). Stage 1 involved examining all transcribed data for a general overview. Stage 2 was included preparing written summary interpretations and necessary coding to determine possible themes in each transcript. Stage 3 consisted of grouping the transcripts as a single unit, categorizing based on the question issues, then analyzing the content, writing main and sub-themes, finding keywords, identifying highlights of the story, and describing the data in detail according to the main and sub-themes. Stage 4 involved reviewing the transcripts or revisiting the participants to clarify any issues or discrepancies in interpreting the data obtained, and then composing a composite analysis of the

various texts. Stage 5 included making comparisons and performing contrastive analyses of the various texts to identify and describe common practices and meanings. Stage 6 focused on determining the constitutive patterns that linked the various themes. Stage 7 involved inviting responses and obtaining suggestions to prepare a final draft by consulting with an associate knowledgeable about the content and/or methodology employed in this study.

2.5. Rigor/trustworthiness

The researcher established a procedural methodology for ensuring data trustworthiness following the concepts of Lincoln and Guba (1985). The lead researcher, an associate nursing professor with 20 years of experience in gynecology and women's health, initiated the introduction to the informants through an interpreter to establish reliability. The informants' perception of the researcher's reliability would impact the accuracy and truthfulness of the information gathered. The process was conducted as in-depth interviews, allowing informants to express their viewpoints openly and comprehensively. To acquire complete and accurate information, the researchers employed various techniques such as repetition in questioning, sampling, and feedback. They verified the accuracy of information gathered from interviews and observations, systematically recording it in summary form. This information was then reviewed with the informants to ensure its correctness. The research team, consisting of nursing instructors experienced in quality research, individually analyzed the information, compiling it categorically until reaching a consensus. For dependability, the study employed "overlapping methods" and provided a detailed methodological description to facilitate replication. A triangular test was conducted by the researchers, who compared their on-location information with data obtained through direct observation, interviews, and group discussions. Additional interviews were scheduled to address unclear issues, repeating the same questions with a different interviewer to assess consistency. Regarding transferability, background data of participants was provided to establish the study's context and offer a detailed description of the phenomenon under investigation, enabling comparisons to be made as necessary.

2.6. Ethical considerations

This research project obtained ethical approval from the Human Research-Ethics Committee of Thammasat University under COA no. 058/2565. All participants were informed of the study and signed informed consent. In the observational data collection, the investigators only took part in the permitted activities. The investigators always asked for permission prior to recording or taking pictures and sought approval before posting any pictures in their research report. The information collected in this study was kept confidential by researchers. All documents were destroyed once the research was complete. Results were presented collectively as a single general illustration. No study results of any individual were referenced. Pseudonyms were used in place of the actual names of the key participants.

3. Results

3.1. Characteristics of the participants

As shown in Table 1, it can be observed that 50% of the Myanmar WRA who worked as migrant laborers were aged between 20 and 24 years, and 70% of them were married. Additionally, 85% of the women identified as Buddhist, and 85% had completed primary school. About 70% had been working in Thailand for 3-5 years, while 65% reported a family income ranging from 15,001 to 25,000 Baht, and 75% stated that their income was sufficient to cover their expenses. Furthermore, 80% had two members living in their households, and 80% did not have any chronic diseases. Regarding employment status, 80% were employed, while 65% did not possess a work permit. Moreover, 70% did not have eligibility for healthcare, and 40% were utilizing services from a primary-care hospital. Approximately 70% were unable to understand conversational Thai.

3.2. Qualitative themes

Two constitutive patterns with relational themes were identified, namely 1) care ineligibility and 2) difficulties in accessing HSs. Detailed problems experienced by women in the Myanmar migrant workforce who were of reproductive age in accessing their HSs are shown in Figure 1.

Table 2. Characteristics of the participants

General information	Frequency	Percentage
Age ($\bar{x}$=31, SD=4.10)		
18-19 years of age	6	30
20-34 years of age	10	50
35 years of age and above	4	20
Marital status		
Single	4	20
Married	14	70
Divorced	1	5
Widowed	1	5
Religion		
Buddhist	17	85
Christian	1	5
Islam	2	10
Educational Level		
Elementary school	17	85
Middle and high school	2	10
Higher education	1	5
Length of time working in Thailand ($\bar{x}$=5, S.D.=3.40)		
2-1 years	2	10
5-3 years	14	70
More than 5 years	4	20
Monthly family income ($\bar{x}$=18,000, S.D.=3.70)		
Under10 ,000 Baht	1	5
10,000-15,000 Baht	6	30
15,001-25,000 Baht	13	65
Income sufficiency		
Insufficient to maintain livelihood	1	5
Sufficient to meet expenses	15	75
Residual income	4	20
Number of family members living at home ($\bar{x}$=2, S.D.=3.10)		
2	16	80
3	3	15
4	1	5
Chronic diseases		
No chronic diseases	18	90
1 chronic disease	1	5
2 chronic diseases	1	5
Employment status		
Employed	16	80
Unemployed	4	20
Had a work permit?		
Yes	7	35
No	13	65
Care eligibility		
Ineligible	14	70
Eligible for HIC / SS card	6	30
Where to receive medical services		
Drugstore	5	25
Clinic	3	15
Private hospital	1	5
Primary-care hospital	8	40
Secondary-care hospital	2	10
Tertiary-care hospital	1	5
Ability to converse in the Thai language		
Unable to understand conversational Thai	3	15
Able to converse in Thai somewhat	14	70
Able to converse in Thai quite well	3	15

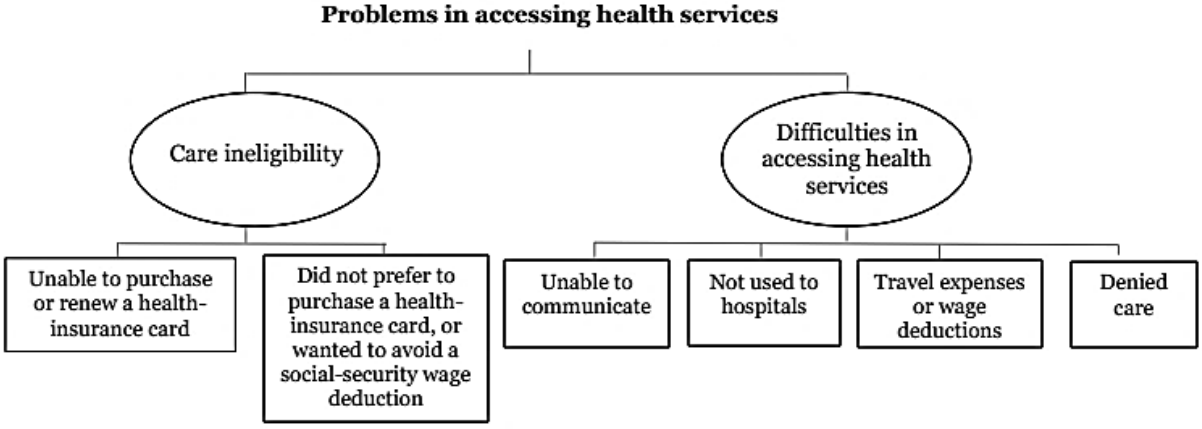

Figure 1. List of themes and sub-themes of the study

3.2.1 Theme 1: Care ineligibility

This theme describes participants' ineligibility to receive care with two subthemes: unable to purchase or renew health insurance card and did not prefer to purchase an HIC or wanted to avoid SS wage deduction.

3.2.1.1 Subtheme 1: Unable to purchase or renew health insurance card

The participants stated that they were workers without passports; thus, they had no health-care welfare. Consequently, they were reluctant to visit hospital. The Myanmar MWs who were abducted and forcibly brought into Thailand had no passports. If they developed symptoms of a serious illness, they did not dare to visit hospital for fear of being arrested and deported. In some cases, they either purchased medication to ease the severity of their symptoms, or they simply ended up dying from their illness. In some cases, they received expensive health-care at a clinic. If they succeeded in gaining admission to hospital, they had no welfare-based care benefit and had to pay the full cost of their care unassisted, forcing them to borrow from their employer. A hospital that provided good care set appointments to monitor the care results. A participant stated the following:

> *I have no passport and I have no regular employment. I have no welfare-based medical care, so that, whenever I am ill, I have to buy my own medicines and take them on my own. Sometimes, I will go to the clinic; but I have to pay a lot of money whenever I go there, so that I end up having to borrow some money from my employer. Right now, I am in debt. It really depresses me. (Cole, showing a stressed facial expression)*

The participants also stated that they were unable to buy or renew a HIC if they had a history of health problems. The hospitals did not sell HICs to MWs, including those who had prior health problems and pregnant women; or, if it was discovered that a worker had a health problem, they did not renew her HIC. A participant stated:

> *When I was five-months pregnant, I was in another province at the time. My health insurance card had expired. When I went to buy new card, they wouldn't sell me one because I was pregnant. It was just awful! (Amitii)*

3.2.1.2 Subtheme 2: Did not prefer to purchase an HIC or wanted to avoid SS wage deduction

The participants mentioned that they chose not to buy a HIC because they did not believe it would provide coverage if they got ill. They would thus be forced to pay for their own care on top of paying for the card.

> *When my relatives get sick, they go to the hospital. They have the card, but they are reimbursed for only part of the treatment cost. It's such a bad situation. They have to lay*

out so many more dollars (deep sighing sound). So, I think it would be better if I just didn't buy the card. (Trixie)

The cost of a HIC was high, and they did not see the need for it. They were quite healthy and robust, and if they became ill, they could purchase medicine at a drugstore. A participant stated:

I'm usually healthy and I don't get sick. I've never had anything wrong with me. The card is expensive, so I'm not planning on getting one. So, the hell with it! I would be just throwing money away! (Irene)

The findings also revealed that the study participants were unwilling to get an SS card, since they wanted to avoid an SS deduction from their wages. A participant stated: *It would be good if my employer paid for all of my social security. I'm not going to go for him paying just one half while I pay the other half.* (Sidney)

3.2.2 Theme 2: Difficulties in accessing health services

This theme describes participants' difficulties in asessing healh services with four subthemes: unable to communicate with medical staff, unfamiliarity with the hospitals where they were eligible for treatment, had to pay the transit fare, and denied care at a hospital where their HIC was registered.

3.2.2.1 Subtheme 1: Unable to communicate with medical staff

The study participants could not communicate with medical personnel well enough to be understood. Thus, the care that they received did not directly address their actual health problems, or they may not have received it in time. Hiring an interpreter to visit the hospital along with the patient added to the cost. Furthermore, although some hospitals had interpreters on duty, the workers could not make it to the hospital, since it was situated too far from their places of work. A participant stated:

*On many times when I go to the hospital, I run into problems. It's terrible**!** I have no idea how I'm going to communicate with the doctor since I don't know Thai (displaying a frowning countenance). If I hire an interpreter to go to the hospital with me, it will cost me even more. But, if I don't hire an interpreter to go with me, the doctor is not going to understand anything I say. So, I just get some paracetamol. Consequently, I never recover from my illness. (Ellie, as she let out a sigh)*

3.2.2.2 Subtheme 2: Unfamiliarity with the hospitals where they were eligible for treatment

Some participants were now eligible to receive treatment. However, whenever an urgent situation arose requiring them to use their right to hospital treatment, they preferred not to go there, as stated by a participant below:

*I'm someone who doesn't like hospitals. Oh**...** I would go to a hospital to be treated for a serious illness or for the birth of my baby. But if I were to become eligible for treatment at a hospital where I have never been before, it would only make it even harder for me to go there. (Mabel, shaking her head)*

3.2.2.3 Subtheme 3: Had to pay the transit fare

The participants also mentioned they had to pay for transit fare to obtain HSs. There could be a deduction from their wages. Although the participants had HICs or SS cards, they were unable to access the services of a hospital where they were registered because of the transit fares. There could also be a deduction from their wages for their time away from work while getting treatment. Two participants stated the following:

My employer has his office in Bangkok. So, he bought my health insurance card for a hospital nearby to his office. But I work right here, and I don't want to go to a hospital in Bangkok because of the time it would take and the cost of transportation. (Alish, shaking her head)

While I was ill, I had to be away from work. So, he deducted it from my wages, and I never got to use my right to be treated at the hospital. If I come down with some minor ailment, I'll just take some medicine that I can buy on my own." (Lana)

3.2.2.4 Subtheme 4: Were denied to receive care at a hospital where their HIC was registered

The participants stated that when they were ready to give birth or were seriously ill, the hospitals where they had registered their HICs refused to provide service on the grounds that they did not have available medical instruments, such as incubators, or specialists. A participant stated:

I was having preterm-labor pains, so I went to the hospital according to my eligibility. They told me that my baby had to be delivered in a premature-birth ward, but there weren't enough incubators available. I would have to go to another hospital, instead. Oh! (Ellie)

4. Discussion

This study explored the problems in accessing HSs experienced by WRA who were members of the Myanmar migrant workforce that had migrated into Thailand. This research found that there are two issues involved in the problems being experienced by the participants in receiving their HSs.

4.1 Ineligible to receive treatment

The findings of this study showed that participants were unable to purchase or renew their HICs since they have no passport, and cannot request eligibility for various kinds of treatment. Furthermore, their labor status is contrary to the law (Information Center for Contacting Government Officials, 2023). Consequently, the MWs are reluctant to visit hospital for treatment for fear of being arrested and deported. In a similar study conducted in Denmark, it was found that the MWs who had surreptitiously entered the country were afraid of being deported. Accordingly, they avoided going anywhere for treatment. Instead, they opted to buy medicine, which they took on their own (Funge & Boye, 2020). In a study conducted in the United States, it was found that immigration status was an obstacle to HS access because of the fear of being deported, while the practice of discrimination was causing a reduction in the use of HSs (Rangel et al., 2019). Although the hospitals in Thailand have not been denying care to MWs, the practice arresting MWs who had entered the country illegally while on their way to hospital has impeded their access to HSs. In these cases, they purchase their own medications and then take them on their own. Some of these people experience severe symptoms, even to the point of death. Some MWs receive treatment at clinics, where they must pay a fee. Even if a worker manages to get to a hospital, that worker is not on treatment welfare, so she is forced to pay the cost of treatment on her own by borrowing from her employer. Some of the MWs cannot meet their payment responsibilities for their medical costs, so that the burden of these costs (Hfocus, 2023; Jongudomkarn et al., 2019; Poonpoksin, 2018) - which may run as high as 14.3 billion US dollars annually (Thai Civil Rights and Investigative Journalism, 2017) - is then thrust upon the hospitals themselves.

The findings also revealed that participants were unable to purchase or renew their HICs if they have a history of health problems. The reason may be that the hospitals are uncertain when the care expenses would be disbursed from the Ministry of Public Health (MoPH), or if certain diseases are eligible for the HIC. The MoPH should clearly specify the diseases for which they may become eligible for treatment and assure hospitals concerning the disbursement of funds. The Ministry should likewise monitor and evaluate its results for the purpose of planning budget-support guidelines aimed at providing HSs to MWs (Thalerngpol, 2020).

This study demonstrated that Myanmar WWs do not want to purchase a HIC, or they do not want a SS deduction from their wages, because the HIC does not cover expenses for being ill. It requires additional payment for treatment. As Sittikan and Jongudomkarn (2020) stated, making arrangements for HSs is a necessary element in providing access to the HSs. The MoPH should therefore consider making eligibility for HIC benefits applicable to MWs while providing adequate coverage for their illnesses. The participants in this study do not want to purchase a HIC because it is expensive, and they do not see the need for an HIC. They are healthy and robust and if they

become ill, they can buy medication from a drugstore. The need to spend money to stay healthy can create a financial obstacle in accessing quality HSs (Thomson et al., 2019). The Government should therefore engage in a public-relations effort to inform the workforce of the benefits of having an HIC, as well as fix the price of the HIC at an appropriate level. Furthermore, it should set a health-promotion policy for the MWs to reduce the rate of becoming ill and having to be treated at the hospital. Furhermore, they participants also mentioned that they do not want an SS deduction from their wages. Although sections 33, 39 and 40 of the law pertaining to SS cards are in force (Social Security Office, 2023), some members of the migrant workforce are still unwilling to apply for an SS card because they do not want any deductions from their wages. It becomes necessary, therefore, to obtain the cooperation of employers on the subject of SS, urging them to explain how the system works for their MWs, and thereby help them to understand the benefits of SS.

4.2 Problems in accessing health services (HSs)

This study showed several problems in accessing HSs among the participants, for example the inability to communicate with medical staff. When the MWs are unable to communicate, the HSs they receive do not correspond to their actual health problems, or the treatment they receive may not be timely. Similarly, in a study conducted by Pandey et al. (2021), it was found that language was an obstacle in the care of migrants. This causes delays in providing the proper care. In a study conducted in England, it was found that problems in communicating in English with service providers constituted a significant obstacle for exiles who wanted access to the available HSs (Fang et al., 2015). The inability to communicate with service providers and medical personnel constituted a lack of opportunity to seek HSs or to access HSs (Reddy et al., 2019). Hiring an interpreter to accompany them to the hospital adds to their total expense; and although some hospitals have interpreters on duty, the workers cannot make it to the hospital since it is situated too far from their places of work. Furthermore, if the interpreter lacks an understanding of medical issues, this could lead to misunderstandings between the doctor and patient, followed by an incorrect diagnosis and, ultimately, to severe consequences like harmful effects from the medication prescribed, permanent disabilities, or even loss of life (Alder, 2023; Fang et al., 2015; Inciso, 2021). For that reason, the medical personnel should master the necessary skills for overcoming the obstacles of communicating in different languages so that these MWs have better access to their HSs.

Another problem in accessing HSs among the participants concern with unfamiliarity with the hospitals where they have treatment eligibility. Although the study participants are eligible for treatment, when they need to use their treatment eligibility at a new hospital, they do not prefer to use the services it offers, because their unfamiliarity with the environment of that new facility causes them a sense of uneasiness (SONIFI Health, 2023). This unfamiliarity is a significant obstacle that causes the MWs to avoid accessing their HSs. Accordingly, the medical staff needs to focus its attention on making the MWs feel at ease rather than isolated and different from the other patients. Staff members should have a positive outlook toward MWs. Furthermore, staff members need to have an understanding of people of migrant background, including their different religions and diverse cultures. They must learn to accept and respect the differences (World Health Organization, 2023) while showing sympathy for those who need their services. They should speak pleasantly, smile, and listen attentively. Friendly facial expressions can help create a stronger bond with migrant laborers.

Furthermore, this study also found that the problems in accessing HSs among MWs are also related to transit fares and that they may suffer deductions from their wages. Although the MWs have SS cards or HICs, they are unable to receive their services at the hospitals where they are registered because of the transit fares. Also, there may be deductions from their wages because of their time away from work while receiving treatment, in spite of what the law now stipulates. Similarly, research conducted in Malaysia, found that services that entail expenses like wage deductions and transportation costs constitute barriers to medical-care access for refugees (Chuah et al., 2018).

The finding of this study also showed that MWs experienced denied treatment from the hospitals where they registered their HICs. When the women of the migrant workforce are ready to give birth or fall seriously ill, the hospitals will often deny them the services they need, claiming they do not have enough instruments and medical personnel. The reason for this situation is that

those hospitals are secondary-care or tertiary-care hospitals. There are limitations in the treatment of certain types of diseases that pertain to equipment shortage, such as in incubators for premature babies. For that reason, prior to distributing HICs, it is necessary to ensure that the workers understand the limited capacity of a hospital in rendering treatment and the system for patient transfer in the case of a hospital with limitations (Sutapuk, 2019). The workers should then be required to repeat it because, as found by the researchers, there were many instances where the migrant laborers appeared to understand what was explained to them, but, when attempting to explain it, they were unable to do so.

5. Implications and limitations

This study reveals that certain MWs face barriers in accessing healthcare due to the inability to afford or renew HICs, leading them to self-pay for treatments. Consequently, low-income workers either avoid hospital care or struggle to access HSs, resorting to self-medication. Variations in medication effects, stemming from diverse physical conditions, drug hypersensitivity, or comorbidities, exacerbate disease symptoms, prompting MWs to seek emergency treatment, complicating nursing efforts. Addressing these challenges necessitates not only improving social welfare for treatments but also providing culturally sensitive medical and nursing care, along with friendly service provision, mindful of their cultural and language differences.

This study has certain limitations. Some participants faced communication barriers with the researchers, necessitating the use of an interpreter. However, the interpreter's limited language skills, despite having around five years of experience, posed challenges. Moreover, the interpreter's accent proved difficult for researchers to comprehend. Therefore, employing interpreters with more experiences is recommended to facilitate smoother communication.

6. Conclusion

This study showed two themes, including care ineligibility and difficulties in accessing HSs. From the research findings, it was further found that Myanmar female foreign workers were not entitled to treatment since they had no passport. They could not afford to purchase or renew their HICs if they had a history of health problems. They did not wish to purchase HICs, nor did they want any SS deductions taken from their wages. They were unable to communicate and were unaccustomed to the hospital setting. They had to pay their own commuting expenses, or there were deductions taken from their wages. In addition, they were denied treatment due to hospital limitations. The Ministry of Health should require that the entire migrant foreign workforce have health insurance without taking into consideration their legal status. They should not need to have their employers certify their entry into the health-care system. Similarly, the Ministry should not need to consider their health status before they are able to purchase health insurance, but should, instead, procure the services of an interpreter at every hospital, since the Myanmar labor force is quite sizeable. Furthermore, the Ministry should develop a health-delivery system to ensure that they will never have the feeling of being denied treatment. A future research should conduct a study on guidelines for improving access to HSs for migrant female workers from Myanmar, as well as a study on a format for providing friendly service.

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Author contribution

All authors (PS, KC, PW and WW) contributed substantially to the study design, data collection, analysis, and interpretation of results. All authors drafted and revised the article, approved the published version, and agreed to be accountable for all aspects of the work.

Conflict of interest

The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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