Factors influencing the utilisation of mental health services among migrant workers in Thailand coming from the Greater Mekong Sub-region

Massimo Galeotti
Italy

57th Master of Public Health/International Course of Health Development
14 September 2020 - 03 September 2021

KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam (VU)

Factors influencing the utilisation of mental health services among migrant workers in Thailand coming from the Greater Mekong Sub-region

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

By

Massimo Galeotti
Italy

Declaration:
Where other people's work has been used (from either a printed or virtual source or any other source), this has been carefully acknowledged and referenced in accordance with academic requirements.
The thesis "**Factors influencing the utilisation of mental health services among migrant workers in Thailand, coming from the Greater Mekong Sub-region**" is my own work.

Signature: 
……..

57th Master of Public Health/International Course in Health Development (MPH/ICHD)
14 September 2020 - 3 September 2021
KIT (Royal Tropical Institute) Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

September 2021

Organized by:

KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

Table of Contents

List of figures

List of tables

Abbreviations

AND	Ante-natal care
PLDR	Lao People's Democratic Republic
DALY	Disability-adjusted life year
GGHE-D	Domestic General Government Health Expenditure
GP	General Practitioner
GMS	Greater Mekong Sub-region
GDP	Gross Domestic Product
HICS	Health insurance card scheme
IOM	International Organisation for Migration
MH	Mental health
MDGs	Millennium Development Goals
MoPH	Ministry of Public Health
NCDs	Non-communicable diseases
OOP	Out-of-pocket payment
PNC	Post-natal care
PTSD	Post-traumatic stress disorder
PHC	Primary Health Care
SSS	Social security scheme
SDGs	Sustainable Development Goals 2030
TB	Tubercolosis
UN	United Nations
UHCSCI	Universal Health Care Service Coverage Index
UHC	Universal health coverage
WHO	World Health Organisation

Glossary

Access to care: utilisation of health services to attain foremost health result (1)**.**
Anxiety: feeling marked by a sense of pressure and anguished thoughts (2).
Country of origin: the migrant's country of nationality (3).
Depression: a medical ailment that adversely influences how one feels, thinks, and acts (4).
Disability Adjusted-Life Years: overall burden of diseases amid a population (5).
International migrant: an individual that changes her/his country of residence (3).
Irregular/illegal/undocumented migrant: a person who enters a host country without authorization (6).
Mental health disorder/illness: status comprising alterations in feelings, thinking, or conduct (4).
Migrant worker/migrant labour: someone who migrates to another country, other than her/his, with the intention to search for employment (7).
Migrant/immigrant: an individual that changes her/his country of residency on a temporary or permanent base for several reasons (8).
Millennium development goals: global United Nations goals (8), signed by 189 leaders aiming at enhancing live for the poorest, between 2000 and 2015 (9).
Post-traumatic stress disorder: psychiatric illness arising in people who have encountered a traumatic experience (war, incident etc) (10).
Regular migrant: a person who enters a host country with authorisation (11).
Stress: response to everyday pressure but can turn harmful when it disturbs routine functioning (12).
Sustainable Development Goal 3: focuses on ensuring and promoting healthy lives and well-being for everyone at all ages (13).
Sustainable Development Goal 3.8: emphasises on UHC and financial risk protection (13).
Sustainable Development Goal 3.8.1: stresses on the coverage of basic health services (13).
Sustainable Development Goal 3.8.2: emphasises people financial protection (13).
Sustainable Development Goals: a set of 17 global goals set up by the United Nations General Assembly to be achieved between 2015 - 2030 and ratified by 193 countries (14).
Utilisation of services: Degree to which individual utilize services currently existing in a country (15).

Acknowledge

Above all, my first and biggest thank goes to Him, whose presence, love, and strength has always been on my side.

All my gratitude goes to my thesis advisor, who with her continued support, professionalism, knowledge, motivation, and insightful feedback, has helped me to sharpen my thinking to write this thesis.

Thanks also go to my course friends, Abeer, Alhadi, Marwa, Odai, Putri and Sujan, whose precious advice, support, and irreplaceable friendship, throughout the Master and beyond, has made this endeavour an unforgettable life experience.

Another big thank goes to Valerio, my brother, and his wife Fulvia who had to take extra duty on my behalf, for me to pursue this Master. And to Matteo, my nephew, who believed in me, since day one and never doubted I could reach the end of this adventure. A golden thank goes to my beloved Yemeni brothers, Rami Hussein and Rami Ahmed, my true strength during this year. Your love, encouragements, endless patience, and trust in me, was felt since day one. Only through you all, it was possible “to do it if for all of us”.

Finally, I want to express immense gratitude to my uncle Giovanni, who among all, paid the highest price for my absence from home during this Master. I will be forever grateful for helping me to pursue my life dream, this achievement is also yours. Lastly, I would like to thank the treasure of my life, my parents Enrichetta e Giovanni, whose love and belief in me has made this journey possible. For their example of love, commitment and hard work has always been an inspiration for me and for my work. All their sacrifices made me the person I am today.

Abstract

Background: In recent years, the number of international migrant workers increased worldwide, particularly in South-east-Asia. Among many health issues affecting labour migrants, mental health is a common condition across all cultures. Studies on migrant workers' access to mental health services from other countries are available but for Thailand little is known. The current Thailand's 4.9 million migrant workers will double in the coming years, raising concern over equitable access to mental health services.

Objective: To describe factors influencing migrant workers' utilisation of mental health services in Thailand, coming from the Greater Mekong Sub-region and to offer suggestions to the relevant stakeholders to further contribute to the Universal Health Coverage country's agenda while leaving no one behind.

Methodology: Literature review guided by "Yand and Hwat" framework describing health service utilisation among migrants was utilized. Peer review studies and grey literature were searched through different data bases. Articles published in English after year 2000 on migrant workers' access to mental health and other health services in Thailand. Articles not mentioning migrant workers' nationality were excluded.

Results: while little evidence was found on mental health services utilisation among migrant workers in Thailand, data on other health services utilisation showed that the following factors are important: financial resources, access to care factors, immigrant status and government policy. Factors that contribute to utilisation were social resources, gender, and marital status.

Conclusion: To increase utilisation of mental health services among migrant workers in Thailand, increasing funding and prioritising mental health interventions, improving current legislations, involving community members, and conducting more research is needed.

Key words: Migrant workers, Thailand, mental health services, utilisation, determinants

Words counts: 12,853

Introduction

I have been working for almost 20 years in the Humanitarian arena, first as a Nurse, then as a Project Coordinator, and lately as Hospital Project Manager, for both international and non-government organisations. Almost a quarter of my twenty years' experience was spent in Myanmar, working closely with Rohingya, one of the most persecuted minorities in the world. Many of them, in the past decades, ran away from their country, spending years abroad, before returning to Myanmar. Several of them shared their personal stories and the ordeal they went through while living as migrant labourer in Thailand. Mental health disorders were the most recurrent issues reported, adding that in Thailand, it was not possible to see someone who could help them with this problem. Many of the people, they worked or lived with, while in Thailand, were so sick and feeling hopeless that at the end they decided to kill themselves. My personal and professional interest, regarding mental health among migrant workers, developed further when I read about the millions of migrant workers living in Thailand, coming from the Greater Mekong Sub region, and I wanted to find out about the governments' responses to address this issue.

The current number of migrant workers in Thailand is estimated to be 4.9 million, and in the coming years, the government has estimated that an additional 4.7 million will be needed to support the country's growing economy. Mental health disorders among migrant workers are increasing worldwide and only little evidence is available from Thailand on migrants' attendance to mental health services. Hence the interest to investigate this matter and to describe determinants impacting migrant workers' utilisation of mental health services. Health is a human right and to leave no one behind a responsibility of governments, that through inclusive policies, need to assure equitable access to mental and health care to all people living in the country.

1.0 CHAPTER ONE: BACKGROUND INFORMATION ABOUT THAILAND

1.1 Background information

The Kingdom of Thailand, also known as Thailand, is a country situated in Asia (16) (Figure 1), and it is one of the 11 nations belonging to the “southern east Asia sub-region” (17). Thailand shares borders with Myanmar on the north and west (16,18), with Lao People’s Democratic Republic (LPDR) (16,19) and with Cambodia on the east, and with Malaysia on the south (16,20). Its coastline consists of 1.875 Km along the Gulf of Thailand and 740 km alongside the Andaman Sea (16). The total land area is 514,000 square Km with a population density of 137 per sq. km (21). Thailand has a population of 69.625.582 inhabitants (2019), of which 51.3% are female (22). Almost fifty percent of the population resides in rural areas (21). In 2018, the literacy rate among females, aged 15 years and above, was 92.4%, and for male in the same age group it was 95.2% (23). With an unemployment rate of 0.77 in 2018 (24), Thailand is among the faster growing economy in South East Asia (25). In less than 40 years, the country moved, from being a low-income to upper-middle-income country. Poverty reduced from 65.2% in 1988 to 9.85% in 2018, but the recent pandemic had an impact on the country’s economic growth, which effects have yet to be seen (26). Thailand is a constitutional monarchy, where the King is the head of the state, and the Prime Minister leads the government multiparty system. Most of the population is of Thai origin (96%), and the remaining are Chinese, Malay, Khmer, Mons, and other hills tribes. The main religion is Buddhism (93%), followed by Islam and Christianity. The country official language is Thai (27).

Figure 1: Thailand and neighbouring countries (28)

The Thai government assigns since years more resources to health (Figure 2) (29) with positive outcomes, such as out-of-pocket payment (OOP) the lowest (11% in the year 2018) among countries in the same area (Figure 3) (30). In 2017 the maternal mortality rate reduced to 37 comparing to 42 per 100.000 live births recorded in 2010. The infant mortality rate in 2019 was eight compared to 12 per 1000 live births in 2010, and the under-five mortality rate in 2019 was 9 per 1000 live births compared to 13 per 1000 live births in 2010 (31).

The number of non-communicable diseases (NCDs) increased in the past 20 years, and among the top 10 diseases contributing to Disability Adjusted-Life Years (DALYs), mental health advanced from being number 10 in 1999 to number 7 in 2019 (Figure 4) (5). The country is undergoing an epidemiological transition that shows an increase on incidence of NCDs, that in 2016 alone accounted for 74% of all deaths (32). In 2019, life expectancy for females was 80.9 (3.63 years more compared to 2009), and for male it was reported at 73.46 (3.09 year increase compared with 2009 data) (33,34)

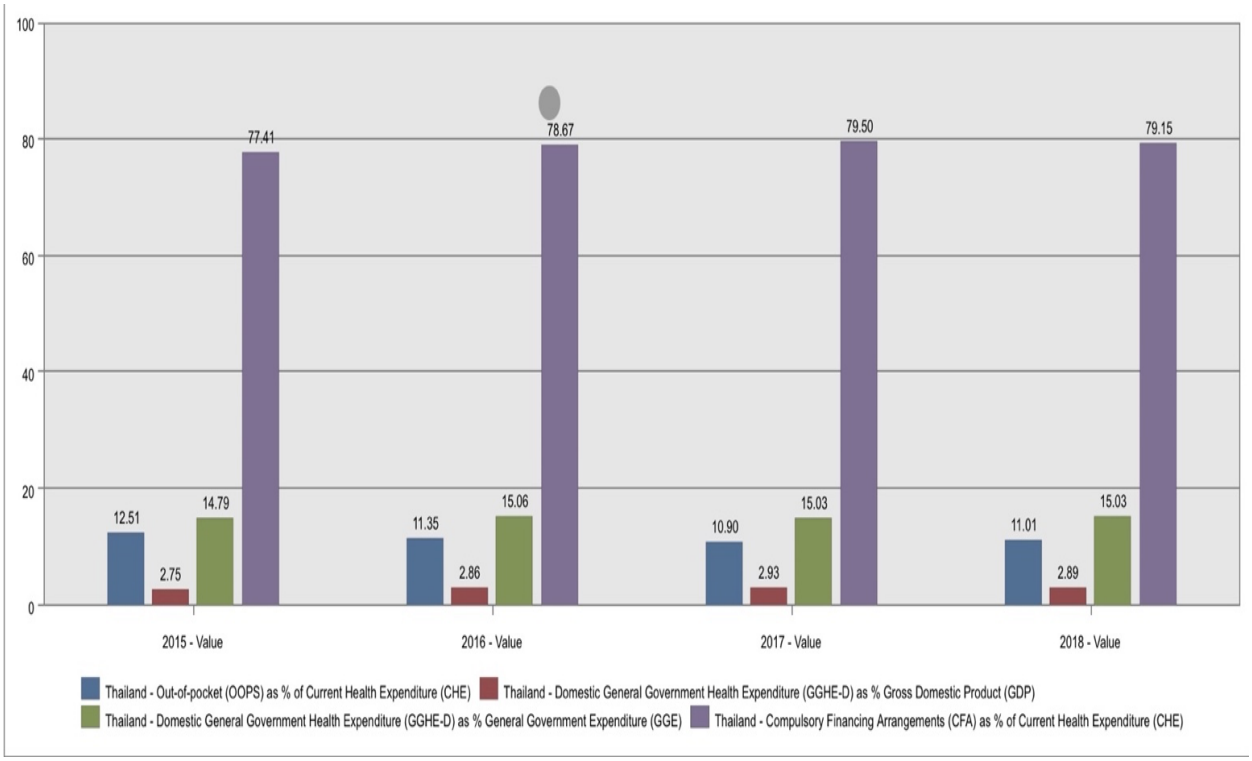

Figure 2: Thailand OOP expenditure; Domestic General Government Health Expenditure (GGHE-D) as %of Gross Domestic Product (GPD); GGHE-D as % of General Government Expenditure; Compulsory Financing Arrangements as % of Current Health Expenditure (29)

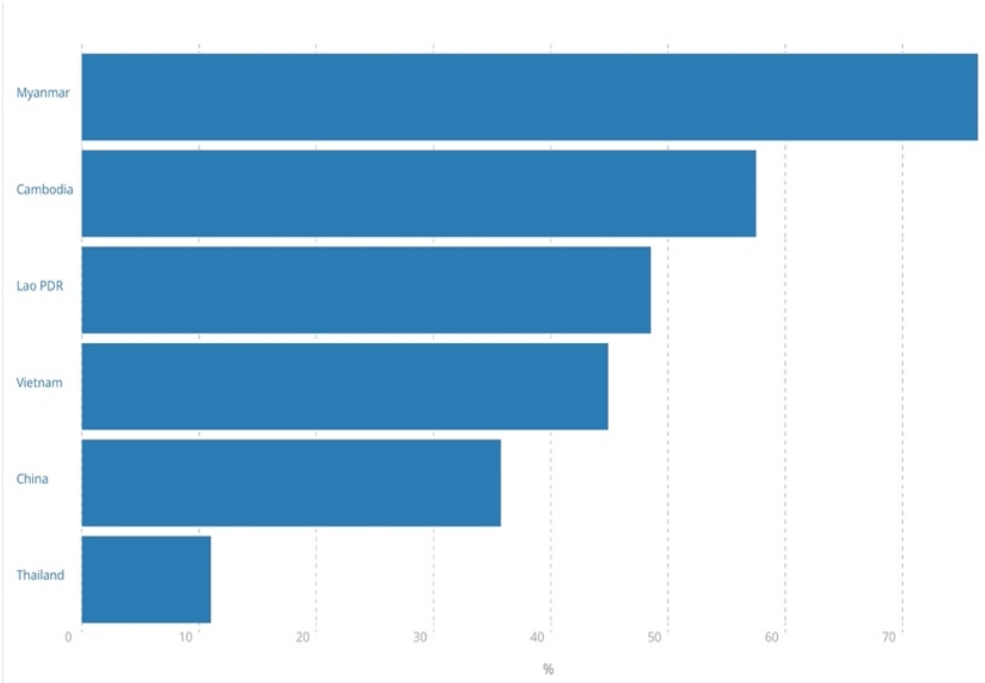

Figure 3: OOP expenditure 2018 (% of current health expenditure) (30)

Figure 4: Thailand, both sexes, all ages, DALYs per 100.000 (5)

In 1992, Thailand, Cambodia, LPDR, Vietnam, Myanmar and two provinces of China (Yunnan and Guangxi Zhuang) launched the Greater Mekong Sub-region (GMS) Economic Cooperation Program (35), a trans-nation region, aiming at strengthening economic relations among the 6 Nations (Figure 5) (36). With a total of 345 million people (37), the GMS, if it was a country, would rank third after China and India (38). Among the GMS countries, only Thailand achieved remarkable economic gains and was able to transition, from being a country that sends out citizens in search of jobs, to be the hub receiving a high influx of foreign workers, mainly from neighbouring Nations (39).

Figure 5: Mekong river and countries of the Greater Mekong Subregion (40)

1.2 Introduction to Universal Health Coverage

Universal health coverage (UHC) is the right of every citizen to benefit from promoting, preventive, treatment, rehabilitative, and palliative care, without suffering financial destitution (41–44). In order to improve and maintain health, access to essential health services is crucial (44) and today, almost 50% of the world population has no access to needed health services, despite an agreement among all UN Member States to achieve UHC by the year 2030 (45). Article 25 of Universal Declaration of Human Rights, proclaims health as a basic human right (46), and this non-negotiable principle introduces the concept of health for all and universal health coverage, that from the Alma Ata Declaration of 1978 to the UN Resolution 67-81 of 2012 and 74-2 (2019),

declares that no one should be left behind (46–49). The transition from the Millennium Development Goals (MDGs) to Sustainable Development Goals 2030 (SDGs), has represented the real breakthrough, to push UHC in the agenda of countries (43). Among the 17 objectives and 169 targets, aiming at peace and prosperity for communities and the entire world (13), SDGs 3 focuses on ensuring and promoting healthy lives and well-being for all at every age, SDG 3.8 emphasises on UHC while 3.8.1 stresses the coverage of health services and 3.8.2 the financial protection, a fundamental concept of UHC. (43,50).

In many low-middle income countries, people using health facilities are required to pay for health services directly at the point of delivery. This method of compensation, called OOP, drives the poor into a more dire financial status, with catastrophic consequences for the individuals and his/her family (43). It is estimated that one in every ten persons around the world, uses at least 10% of his/her household budget to pay for healthcare, pushing him/her into poverty, while the OOP expenditure is responsible for causing poverty to a 100 million people every year (42). A person benefitting from good health can increase productivity and support its family, as well as community and society needs. Families with a reduced financial risk, can utilise the money to satisfy other needs, diverting the available funds into the economy. Lastly, healthy children can attend schools and acquire education, that will prepare them to become active members of their community (41,43). To attain UHC, there are three areas in which countries need to move forward, and Figure 6 depicts clearly each one of them: the portion of people that need to be covered, with emphasis to leave no one behind; the services to be offered and lastly the percentage of the cost to be reached by pooled funds (51).

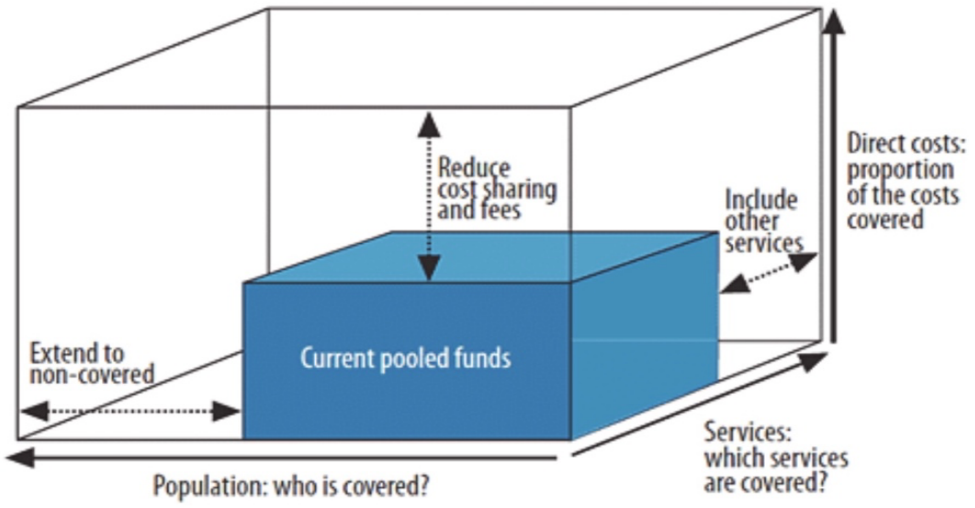

Figure 6: Three dimension of UHC (52)

Universal Health Care Service Coverage Index (UHCSCI) helps following countries' progress towards UHC, by measuring the coverage of health services (SDG 3.8.1) on a scale of 0 to 100. It includes 16 indicators, divided into four groups: 1) reproductive-maternal-new-born-child-health; 2) infectious diseases; 3) NCDs; 4) service capacity and access. The Global Monitoring Report 2017 "Tracking Universal Health Coverage" compares data from different countries divided in geographical areas. On the top of the list, with a higher UHCSCI, is North America, Europe and East Asia, each with a score of 77, followed by Southern Asia with 53 and Sub-Saharan Africa with 42 (Figure 7) (53).

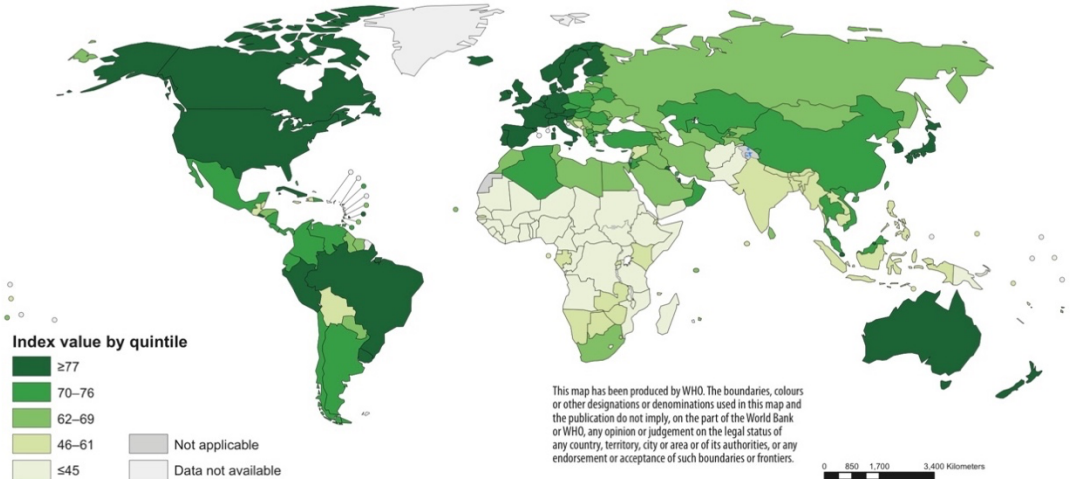

Figure 7: UHC service coverage index by country, 2015: SDG 3.8.1 (53)

1.3 Thailand and UHC

Back in 2002, Thailand's commitment to UHC was enhanced by the National Health Security Act, affirming that "Thai population shall be entitle to a health service with such standards and efficiency" (54). In the same year, UHC was launched, to offer health coverage to all Thai citizens. Three national health insurance schemes were used: the civil servants' medical benefit scheme, supervised by the Ministry of Finance; the social security scheme (SSS) overseas by Ministry of Labour; and universal coverage scheme controlled by the Ministry of Public Health (55–58) (Figure 8). In 2019 Thailand had one of the highest percentage (98%) of citizens, covered by health insurance, amid southeast Asian nations (59,60) (Figure 9) with a UHCSCI of 85% (on a scale of 0%-100%), the highest among the same group (61).

Scheme	Population coverage		Financing sources	Benefits package	Purchasing relation	Access to service	Per capita expen-diture 2010
Social Security Scheme (SSS)	Private sector employees, excluding dependants	16%	Payroll tax financed, tri-partite contribution 1.5% of sal-ary, equally by employer, employee and govern-ment	Comprehensive: outpatient, inpatient, accident and emergency, high-cost care, with very minimal exclusion list; excludes prevention and health promotion	Contract model: inclusive capitation for outpatient and inpatient services	Registered public and private competing contrac-tors	US$ 71
Civil Ser-vant Medi-cal Benefit Scheme (CSMBS)	Govern-ment em-ployees plus dependants (parents, spouse and up to two children age <20)	9%	General tax, non-contributory scheme	Comprehensive: slightly higher than SSS and UCS	Reimburse-ment model: fee for service, direct disbursement to public providers for outpatients; conventional DRG for inpatients	Free choice of public providers, no registration required	US$ 367
Universal Coverage Scheme (UCS)	The rest of population not covered by SSS and CSMBS	75%	General tax	Comprehensive: similar to SSS, including prevention and health promotion for the whole population	Contract model: capitation for outpatients and global budget plus DRG for inpatients	Registered contractor provider, notably within the district health system	US$ 79

Figure 8: Characteristics of Thailand's three public health insurance schemes after achieving UHC in 2002 (55)

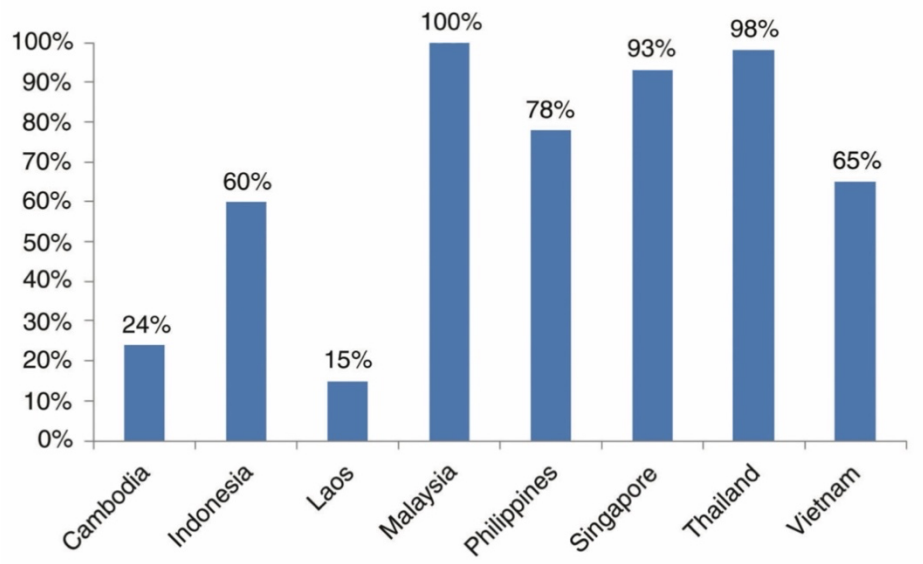

Figure 9: Coverage of health insurance among Southeast Country (59)

2.0 CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION, AND OBJECTIVES

2.1 Problem statement

2.1.1 General migration

In recent years, wars, political instability, economic crises, environmental and climate change, the search for better job opportunities, have been identified as responsible causes for increasing migration around the globe. In 2019, the number of international migrants worldwide was 272 million (62,63), an extraordinary figure, considering earlier projections, that forecasted a total of 230 million by the year 2050 (62). Migration among countries sharing borders, is a phenomenon particularly important in South East Asia, mainly between Thailand and neighbouring countries (62). The International Organisation for Migration (IOM), estimates a total of 27.5 million migrants in Asia alone, of which 1/5 are moving within the GMS (64,65). Just over a period of 5 years, the number of non-Thai residents has increased by 32%, from 3.7 million in 2014 to 4.9 in 2018, confirming once more the country as the centre of migration within Southeast Asia (39).

2.1.2 Increase in migrant workers in Thailand

In 2018, among the non-Thai residents present in the Country (4.9 million), 82% were migrant workers, 4% people were on a temporary stay (foreign married with Thai, retired and investors), 0.6% students, 11.2% other population without citizenship (ethnic minority and hill tribes, stateless persons) and 2.1% refugees and asylum seekers (38,65). A migrant worker is defined as someone who migrates to another country, other than her/his, with the intention to be employed (7). Approximately half of the migrant workers are legally registered in the country, while the rest are illegal (38,65). The low rate of unemployment in Thailand, the persistent economic development, coupled with a decreasing birth rate and increasing aging population, will see a surge of labour migrants entering the country in coming years (38,64). Pushed by unequal economic development between, rural and urban areas, the number of Thai citizens leaving the country, in search for better paid jobs, will increase, encouraging more people from neighbouring nations to cross over. The Thai government estimates that an additional 4.7 million job vacancies will need to be filled in the coming years, and migrations will help to bridge the gap. Figure 10 shows the evolution of migration in the country from 1990 to 2015 (39).

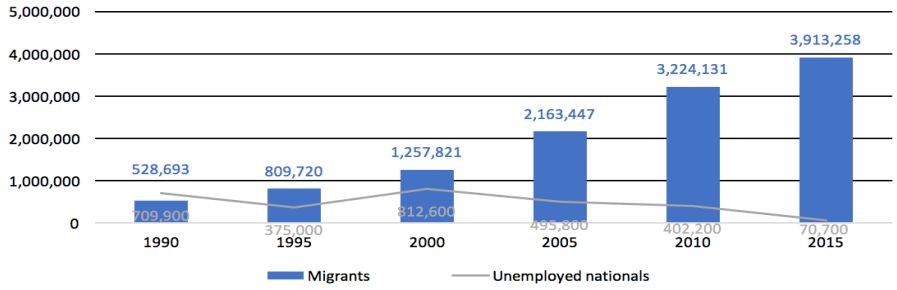

Figure 10: Migrant stock and unemployment of nationals in Thailand (1990–2015) (39)

2.1.3 Health insurance schemes coverage for migrant workers

Migrants in Thailand are employed in the formal and informal sector, with only the former covered by the SSS (57). But just 64% of migrants covered by SSS benefit from it (39). To provide health care and work permits to the illegal immigrants, employed in the informal sector, the Ministry of Public Health (MOPH) launched the "health insurance card scheme (HICS) for migrants" in 2014. Not all migrants can be enrolled in the schemes, as candidates must pass a medical test for severe diseases such as leprosy, elephantiasis, stage 3 syphilis, drug addition, alcoholism, and active TB. The candidate should also not suffer from mental diseases. The insured worker can choose between 3 types of schemes (Annex 1) that covers inpatient and outpatient care, emergency therapy, health promotion activities, but do not include dialysis and treatment for psychosis and drug dependence (57).

2.1.4 Migrants and health issues

Migrants' health is a public health concern and key to a right-based system that attempts to lessen health inequities, by moving forward to the UHC (65,68). Actions taken to deal with the health needs of migrants improve their health status, tackle the issue of stigma, support integration, preserve global public health, and add to social and economic development (68). The issues affecting migrants include infections contracted during the journey, sexual harassment, exploitation, work-related injuries, physical violence (69), and malnutrition. NCDs such as diabetes and hypertension are also common (69). One mutual condition that emerged from studies in different countries, is the increasing burden of mental health (MH) disorder among migrants, ranging from depression and anxiety to substance abuse (69–72).

World-wide MH is a major cause of disability (72,73), and is included in the SDGs agenda (SDGs 3.4 and 3.5) (13). The three main conditions affecting mental well-being are: neurological conditions, substance use, and other addictive behaviours (71). A complete list of disorders can be found in Annex 2. From 2007 to 2017, MH conditions increased by 13% worldwide (72). Almost 970 million of the world population (13%) suffers from mental diseases, caused by neurological conditions (10.7%), alcoholic use disorder (1.4%), and drug disorders (0.9%) (71). Global burden of MH went from number 13 in 1990 to number 7 in 2019 for all causes (Figure 11) and from number six to number five among NCDs (Figure 12) (74). Among migrants, dissimilar accounts report the magnitude of MH disorders, from 12% amid Myanmar immigrants in Thailand (75), to 30% within Cambodian migrants returning home from Thailand (76), and 50% among Syrian, Afghan, and Iraqi migrants in Germany (77), to 15.6% amid migrants from 20 different countries (Caribbean, North America, Europe, and Asia) (78).

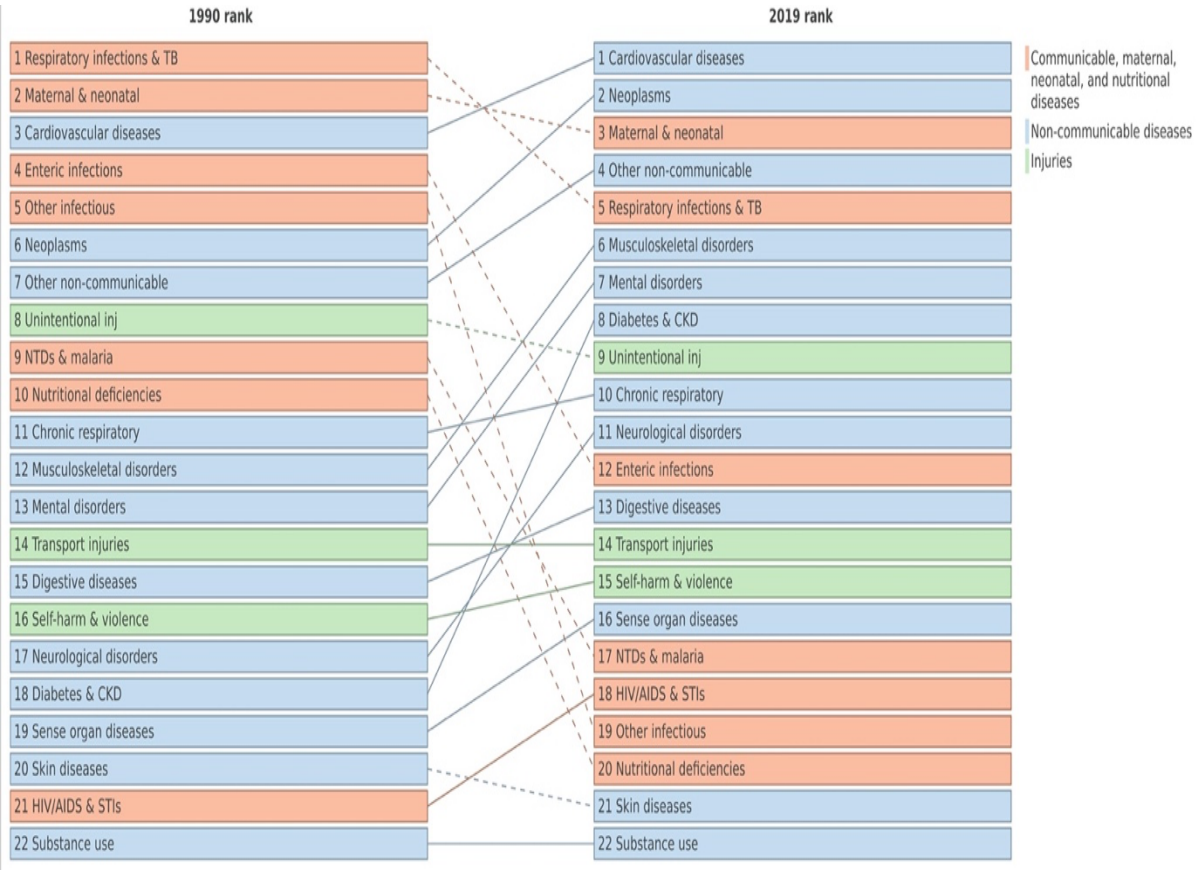

Figure 11: Global both sexes and all ages, DALYs per 100.000 for all causes (74)

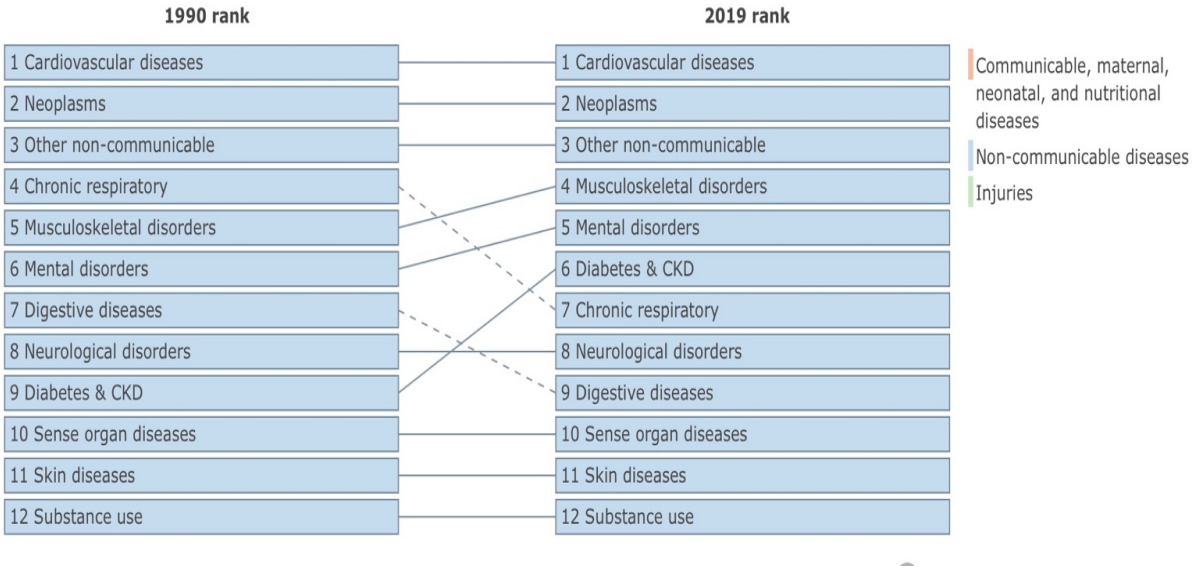

Figure 12: Global both sexes, all ages, DALYs per 100.000 for non-communicable diseases (74)

2.2 Justification

2.2.1 Current evidence related to migrants' utilisation and barriers to mental and health care in Thailand

A combined assessment, carried out by IOM and Thai Ministry of Public Health (MoPH), acknowledged the limited or no access to health services amid migrants present in Thailand. Several obstacles, hindering the utilisation of health services among migrants were identified, such as fear of arrest and repatriation (among the illegal immigrants) and not having enough money to pay for the service. Language and cultural barriers were also recognized as essential causes influencing health service utilisation. Lastly, the health workforce's attitude, behaviour, and stigma towards migrants can also prevent access to care (79). However, little is known about the utilisation of mental health services among migrant workers in Thailand and what influences it, but studies from other countries acknowledged the low attendance. In Montreal, for instance, a survey amid migrant workers (1703) from Vietnam, Philippines, and Caribbean and 865 residents, determined that just 5.5% of migrants used MH services compared with 14.7% of the residents. (80). The same findings emerged from a similar study in British Columbia among 148.973 Chinese immigrants and a same size comparison group of native people. Almost 21% of immigrants sought MH support compared with 39.3% of the comparison group (81).

2.2.2 Rational for this study

Health is a fundamental human right, and its provision to people living in a country should not be constrained solemnly based on nationality or work permit. Migrant workers in Thailand are the backbone of the country's economic growth, as recognized by the authorities, and its already high number will double in the coming years, as projected by the government. With data worldwide showing an increase of the MH burden among labour migrants, with severe consequences for the individual and the supported family, it is pivotal to provide services that are accessible to this group. The government's effort to reach UHC by 2030, has gained remarkable achievements since its inception in 2002, but is this plan inclusive or are there some left behind? There is evidence showing limited utilisation of health services amid migrant workers in Thailand and reasons why, but little is known about the uptake of MH services among immigrant workers and influencing factors. Thus, the outcome of this study will help government institutions, governmental and non-governmental organisations to understand factors influencing the utilisation of MH services among migrant workers. It will help to design inclusive interventions aiming at supporting the mental wellbeing of this vulnerable group, that ultimately will benefit the mental wellness of the individual that in return will be more productive at work, contributing to further development of the nation.

2.3 Objectives

2.3.1 Overall Objective

To describe factors influencing the utilisation of mental health services, among migrant workers in Thailand coming from the Greater Mekong Subregion, and to provide recommendations to the Ministry of Public Health, Ministry of Labour, Research Institutions, non-government organisation, and development partners, to further contribute to the Universal Health Coverage country's agenda while leaving no one behind.

2.3.2 Specific objectives

a) to describe the mental health needs among migrant workers in Thailand coming from the Greater Mekong Subregion
b) to analyse resource factors influencing the utilisation of mental health services among migrant workers in Thailand coming from the Greater Mekong Subregion
c) to analyse predisposing factors affecting the utilisation of mental health services among migrant workers in Thailand coming from the Greater Mekong Subregion
d) to analyse contextual factors prompting the utilisation of mental health services among migrant workers in Thailand coming from the Greater Mekong Subregion
e) to provide recommendations to the Ministry of Public Health, the Ministry of Labour, Research Institutions, non-government organisations, and development partners regarding inclusive policies for migrant workers while moving towards universal health coverage

3.0 CHAPTER THREE: METHODOLOGY

3.1 Research method

This thesis is based on a literature review of available published articles, peer reviews, and grey literature. The search strategy adopted includes internet search through Pub Med, Vrije University literature database, Google scholar, Institution Websites such as World Health Organisation (WHO), United Nations (UN), United Nations Development Programme, World Bank, UHC 2030, IOM. Grey literature was searched on international organisations' websites and Google engine. The search continued through Thai Ministry of Health website. The language used for the search was English. Table 1 summarizes the research strategy.

Table 1: Search strategy

AND				
Greater Mekong Subregion	**Migrant workers**	**Utilisation of services**		**Influencing factors**
Thailand Myanmar Laos Vietnam Cambodia Yunnan and Guangxi Zhuang Province China Asia	Immigrant worker Emigrant worker Expatriate worker Itinerant worker Nomad worker	Access Use Uptake	**OR**	• Mental health issues – mental wellbeing – mental stability • Specific mental health needs • Financial resources – resources - assets – available funds – cash – money – savings • Social resources – social capital – social networks – social relationship • Access to healthcare – entry – entrance – admission – ingress - • Homeland-based financial and social resources – country of origin – mother country – native land – land of birth – land of origin – native soil – place of origin – place of birth • Transnational access to healthcare – trans country • Demographic – age – gender – race – marital status – ethnicity • Socioeconomic status • Health beliefs – opinion – feeling – impression – faith – notions – attitude – knowledge – values • Genetic factors – hereditary – patrimonial – inborn – heritable – chromosomal – genomic

				• Immigration status – position – ranking – condition – situation • Assimilation – absorption – acculturation – adaptation – • Immigration ethnic culture – traditions – heritage – habits – values – education • Government policy – guidelines – protocols – plan – procedure – arrangement – strategy • Healthcare system – health service - care • Social, economic & political conditions – economic recession – low income – civil war – domestic unrest – social disorders • Context of emigration – background – situation – conditions • Context of reception • Health service utilisation in the homeland – usage of health service – use

3.2 Inclusion criteria

Reports, guidelines, and articles discussing the utilisation of MH and health services among migrant workers in Thailand or other countries of the GMS, published after the year 2000, in English, were included.

3.3 Exclusion criteria

Literature published before the year 2000 was excluded from this study as well as articles written in languages other than English. Articles discussing utilisation of MH care, that did not mention the nationality of the migrants, were excluded from the study.

3.4 Limitation of the study

Not many articles were found on factors influencing utilisation of MH services among migrant workers in Thailand, and restriction on the year of publication coupled with language preference (English) might have limited further the finding of studies relevant to this thesis. Primary data collection might have been the best way to acquire accurate and up-to-date findings, but due to the current pandemic and fear of limited available time to conduct this study, I opted for a literature review. Some studies provided data on the migrants' MH status, by developing a self-grading check list, as supposed to utilize trained mental health staff.

3.5 Framework

The theoretical framework utilized in this study is the “Yand and Hwant” model, specifically designed to describe health services utilisation (HSU) among migrants, thus pertinent to this thesis study. Yang and Hwant modified the original and still valid Andersen’s framework by adding a fourth category called “macrostructural/contextual factors” that takes into consideration government policies, healthcare system, political conditions, the context of emigration and reception, and health service utilisation in the homeland.” Each one of the main 4 blocks of this model (macrostructural/contextual factors; predisposing factors; resources-enabling factors; the need for health care) can be described both at general and immigrant-specific levels (Figure 13) (82). Developed in 2016, this framework has been utilized in several studies, where Andersen’s conceptual framework could not answer questions specifically related to migrants’ HSU because not included in the conceptual model (83,84).

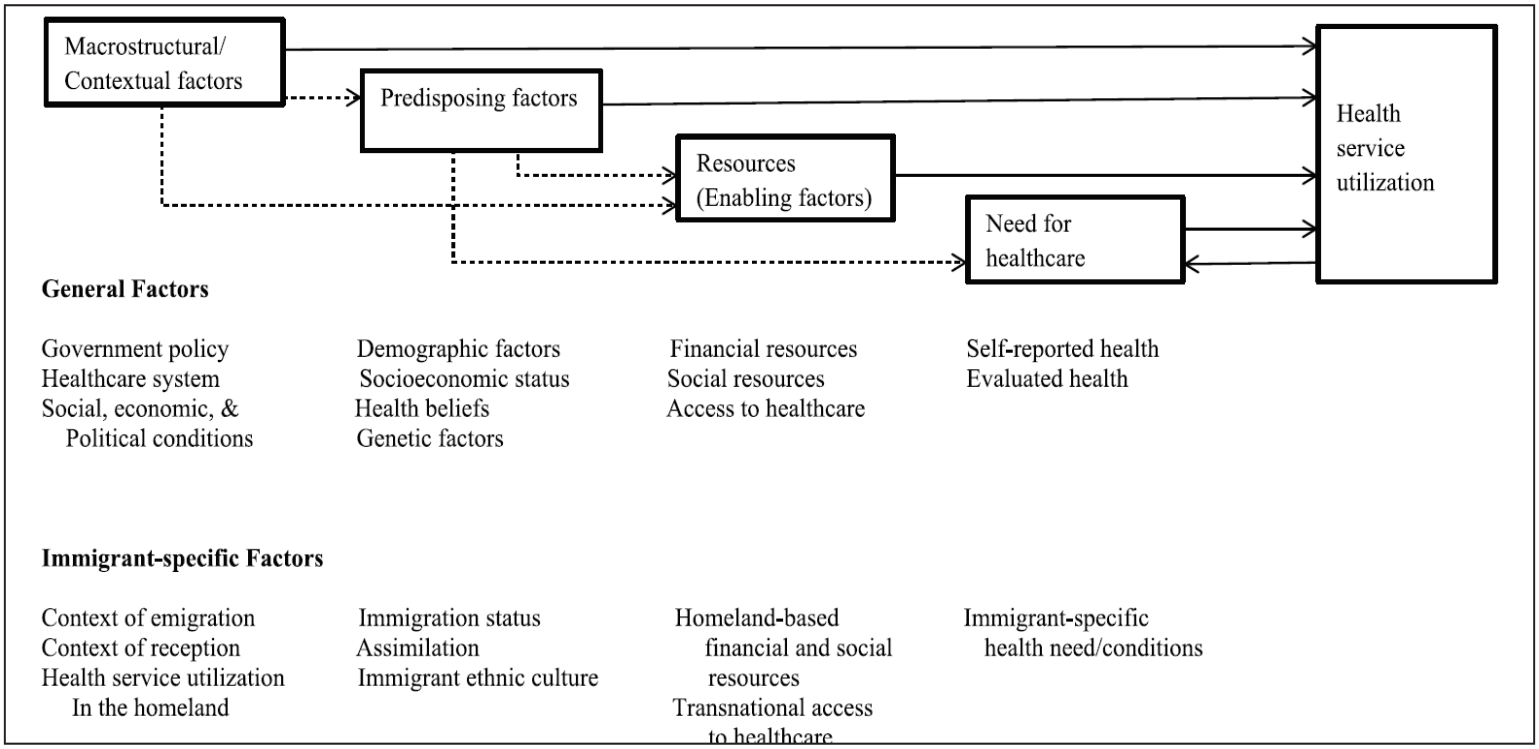

Figure 13: Yand & Hwant analytical framework for immigrant health service utilization (82)

4.0 CHAPTER FOUR: STUDY RESULTS AND FINDINGS

4.1 Mental health needs among migrant workers

Prevalence of mental health illnesses among migrant workers in Thailand coming from the GMS, was searched for through Thai Government official website, but no data was identified. Conversely, journals and peer review articles were found, and main findings are reported below and in table 2.

A study carried out among Myanmar's legal migrant workers, employed in factories and fish industry in Thailand, found a depression rate at 4%, anxiety at 3%, and a combination of both at 5%. (75). Additional reports among the same ethnic group, found depression ranging between 29% and 38%, and anxiety from 17% to 21.8% (85). Using a self-reported questionnaire, researchers asked Cambodian legal migrant workers, to measure symptoms of depression, and 69.7% of the total 1.211 participants, reported signs of the disease (86). In a separate study among migrant workers, employed illegally as fishermen and coming from Myanmar and Cambodia, symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) were reported at 54.4%, 44.9%, and 39.4%, respectively (87).

Additionally, a qualitative study among 70 LPDR migrant workers in Thailand, showed a high rate of stress, linked to different causes: low and not regular wages (35.7%); job insecurity (28.6%); loneliness (14.3%) (88). Although the study only discussed issues of stress, mental health professionals have shown a strong link between stress and the onset of MH disorders, such as depression and anxiety (89,90). In a face-to-face interview with 1102 migrants, who returned to their native land, following a working experience in different Asian countries (Vietnam, Cambodia, Thailand, LPDR, and Myanmar), 61.2% reported symptoms of depression, 42.8% of anxiety, 38.9% PTSD and 5.2% attempted suicide (91).

Among the most important MH conditions affecting migrant workers in Thailand, depression is number one, followed by anxiety, post-traumatic stress disorders, and suicidal attempts. It is not possible to get a clear picture of the proportion of each condition, but rather a range of percentages. Depression can vary between 4% among Myanmar legal workers and 69.7% amid Cambodian legal migrant workers. The type of employment and legal status of migrants might be linked to mental disorders. For instance, within Myanmar legal and illegal workers, migrants employed in the agriculture sector, experience a lower percentage of depression compared to those engaged in the sex industry (29.8% and 38.8%, respectively). No regular wage, Job uncertainty, and feelings of loneliness have been identified as major causes of stress among LPDR migrant workers.

Table 2: Mental health issues among migrant workers coming from GMS

Source	When the study was conducted	Migrant workers country of origin	Status of migrant workers	Results	Type of employment
Kesornsri S, et al. (75)	2019	Myanmar	Legal migrant workers	Anxiety: 3% Depression: 4% Anxiety and depression: 5%	Factory Fish processing
Meyer SR, et al. (85)	2015	Myanmar	70% legal migrant workers	Depression: 29% (agriculture workers) 33% (factory workers) 38% (sex industry) Anxiety: 17% (agriculture workers) 9.7% (factory workers) 21.8% (sex industry)	Agriculture Factory Sex industry
Laohasiriwong W, et al. (86)	2018	Cambodia	Legal migrant workers	Depression: 69.7%	Agriculture Construction Household Industry Animal husbandry
Pocock NS, et al. (87)	2014	Cambodia Myanmar	Illegal	Depression: 54.9% Anxiety: 44.9% Post-Traumatic Stress Disorder: 39.4%	Fish processing
Nilvarangkul K, et al. (88)	2010	Lao PDR	Not mentioned	High level of Stress linked to: • No regular wage 35.7% • Job uncertainty 28.6% • Loneliness 14.3%	Not specified
Kiss L, et al. (91)	2010-2013	Vietnam Cambodia Lao PDR Myanmar Thailand	Illegal	Depression: 61.2% Anxiety: 42.8% Post-traumatic stress disorder: 38.9% Attempt suicide: 5.2%	Fishing industry Factory workers Sex industry

4.2 Resources factors to utilise mental health care

Resources are the means facilitating people to obtain health care and to access health services (82).

Financial resources

Availability of money can impact health service utilisation and the purchase of a health insurance package among migrant workers (82). Evidence on financial resources and utilisation of MH services among migrant workers in Thailand were searched, but not found. However, the search included other health services utilisation (tuberculosis (TB), Hospital, general health centre).

In a study among 621 legal migrant workers, coming from LPDR in Thailand, more than a third stated that in the previous 12 months, they did not visit a health centre because of lack of money (92), the same reason was highlighted by illegal Myanmar migrants workers in a different study (93), and in a WHO and IOM survey among LPDR, Cambodian and Myanmar migrant workers in Thailand (94).

Self-medication among illegal migrants from LPDR, Cambodia and Myanmar is a common practice because this is cheaper than visiting a health professional and having to pay for the consultation (93–95). Indirect costs, such as transportation and loss of hours at work, are also considered barriers for seeking care at government-run facilities, according to a study among Myanmar unregistered migrants (93,94).

Instead, investigation among 861 Cambodia migrant workers, employed in fruit plantations, established that 25% of labourers were working without legal documents and not having enough savings, prevented them from purchasing health insurance as well as pay for transportation to reach the closest clinic.

The same study also acknowledged that 69.2% of the workers were familiar with the practice of borrowing money from their manager, mainly to pay for hospital bills (96). A different research, among Myanmar immigrants and refugees in Thailand, who received treatment for TB, 82% (888 of the total) sought free care in non-governmental organisation clinics, compared to 18% that instead could afford to pay the cost of the treatment by attending public hospitals (97).

From the above, lack of financial resources prevents people from attending healthcare, pay for commute to the health centre, and can halt the purchase of health insurance packages. Concerns over missing working hours, resulting in lower wages, to visit a health centre, can also desist migrants from seeking healthcare.

Social resources

Social networks between migrant workers and their family and community members as well as friends and peers, can support disseminating information, related to health, and spur endorsement of health behaviours (82). Articles were found on social resources for MH and migrant workers in Thailand, with additional evidence on other health services for migrants used for triangulation.

Talking to family members, friends, and neighbours, when suffering from MH disorders was identified as the primary source of help for pregnant Myanmar refugees and migrants mothers in Thailand (98). A qualitative study among 80 Myanmar legal migrant workers in Thailand, carried out in 2019, featured challenges this group faces in the host country, from MH and other medical conditions to difficulties in finding housing and job opportunities. Nonetheless, with family and community members' support, peer and community leaders' care, migrants have found help to overcome difficulties (99).

Emergency healthcare In Thailand is provided free of charge to illegal migrants, but often among new comers, this notions is missing due to lack of connections between the new arrivals and the existing migrant community (95). In a research, focusing on the use of ante-natal care (ANC) and post-natal care (PNC), among 345 Cambodians working in Thailand, immigrants with one or more social recourse were found to have more chances to attend PNC clinics (100).

A Myanmar migrant worker recalled her positive experience with social network regarding her pregnancy: "When I got pregnant, my employer said, there is a clinic across the river, go there. I also have friends that got pregnant. They told me, you can go there, you can get checked there" (99).

In summary, when suffering from MH disorders, family, friends, and community can support those in need. Evidence related to other health services (mother and child healthcare) also shows that the social network is important to share health-related information and endorse health behaviour. Conversely, lack of connectivity between "new" and "old" migrants, prevents the dissemination of beneficial information, supporting the evidence, that social resources play an essential role among migrant workers and their use of health services.

Access to health care

Having the right staff, doctors, nurses and translators, working with a friendly attitude, and many health centres spread in the territory, easy to reach, functioning well, and with sound equipment can influence the utilisation of health services among migrants (82).

Article looking at factors influencing migrant workers' access to health services was used as poxy for assessing migrant workers' access to MH services in Thailand. The evidence shows that migrants who don't speak Thai, face difficulties when visiting health centres, as a language barrier can negatively hamper diagnosis and treatment (93,95,101,102). The importance of speaking the local language is also reflected in a study carried out among Myanmar migrant workers, where the utilisation of governmental hospitals was higher, among those who could communicate and understand Thai, compared with those who were not able to speak the language (71.1% and 48.8% respectively) (94). A qualitative study surveyed the use of ANC and PNC among 3.555 migrant workers, coming from Myanmar and Cambodia and reported that parents, who could talk Thai, were eight times more likely to utilise post-natal care services compared to those who could not speak the language (100).

Buying drugs, for self-medication, is common among migrants, who are not able to speak Thai, than among those who can (34.4% and 20.7% respectively) as clients do not need to be examined and questioned by the pharmacy staff on the health problem (94). Among 1337 illegal migrant workers from Myanmar, who took part in a qualitative study, 40% admitted having had access to health services within 12 months prior to the study. Those who visited private health clinics, gave several reasons: presence of facilities in key areas of the district easy to access (94); secondly the working hours of private clinics met the expectations of the migrant workers, since they open from early morning until late at night; thirdly the waiting time to see a trained medical staff, is less compared to public clinics (94,103). Lastly, private health facilities do not enquire about the legal status of the migrants (94).

In a research of Cambodian migrant workers were 80% held a regular working permit, the far distance to the public hospital was not a deterrent from seeking healthcare because the location was well connected through transportation (96). A non-friendly attitude of health staff (95,103) and poor clinic infrastructure coupled with not functioning equipment, can also prevent people from visiting the health centres (95). Myanmar legal migrant workers, in a qualitative study conducted in 2020, underlined that among health staff, doctors are more caring and behave better than nurses, thus they prefer seeking healthcare in hospitals where doctors are employed rather than in health centres usually run by nurses (103).

To summarize, evidence-based on utilisation of Hospitals and ANC-PNC clinics among migrant workers in Thailand, showed that the language barrier between patients and heath staff, is a major obstacle to access healthcare. The migrant workers' specific needs can also determine the use of health structures, (clinic working hours, short waiting time and proximity to the place of residence). If the facility is easy to reach with transportation, migrants find it feasible to use services. Lastly, health staff behaviour, good infrastructure, and defective equipment can influence the decision to visit healthcare centres.

Homeland-based financial and social resources

Migrants, unlike local people, could also have access to financial resources coming from their country of origin, thus increasing their funding, that ultimately could facilitate HSU. The migrants' social connection usually expands beyond the ones of the host country, hence providing more options to get free and cheaper health care from their native place (82).

The literature search found no studies related to this factor.

Transnational access to mental health care

Migrants "enjoy" flexibility in terms of accessibility to health services, being in the position to choose between their native and host country (82). No evidence was found in relation to migrant transnational access to MH care. Other health related services (TB Clinic) provided the following evidence.

A study was carried out in Thailand near the border with Myanmar (Karen state) to investigate the prevalence of TB among Thai residents, Myanmar refugees and migrant workers. Amid 1662 TB positive cases registered, 65.4% were from Myanmar of which 37% (400) were migrant workers, 23% (248) refugees and 38% (415) cross-border immigrants (97). The phenomenon of cross-border migration from Myanmar to Thailand is explained by the inability of medical structures in Myanmar, to provide diagnosis and treatment for TB (104) (97).

In summary, the forementioned findings, though not directly linked with the subject of this study, highlight the difficulties, Myanmar citizen have returning to their country of origin to seek healthcare, as evidence shows the inability of the Myanmar health systems to respond to the needs of their citizens.

4.3 Predisposing factors

In discussing the utilisation of health services, predisposing factors are circumstances demonstrating the tendency to use health services (82).

Demographic factors

Demographic factors are elements used to explain the attributes of a person or a population in relation to the utilisation of health services, including MH (82). Evidence to relate demographic factors and MH services utilisation, among migrants, was conducted but no evidence was found. Consequently, search for demographic factors among migrants and HSU was carried out instead.

A cross-sectional study on LPDR regular migrant workers showed that the married people were 2.7 times more likely to utilise health services compared to non-married workers (92). Another study among migrant workers couples from Myanmar and Cambodian, demonstrated that the presence in the host country of both parents, increased the likelihood for the children to be taken to the health centre, compared with a single-parent family (100).

Also, ethnicity can influence the utilisation of services. A qualitative study carried out in 2004 among Myanmar migrant workers, living in Thailand, revealed that almost three-quarters of the total of 208 migrants, belonging to Burmese and Mon ethnic group, uses the government hospital when they feel unwell, compared with just one third (of a total 191) of the Karen ethnic group. The same study highlighted the ability of Karen to better endure diseases compared with Burmese and Mon, also to use health services only when they are extremely unwell (94)

Myanmar females migrant workers who took part in a qualitative study, admitted to be the responsible person in taking the decision whether to bring the child to a clinic or not, and not males in the household (99).

Among demographic factors influencing the utilisation of health services, ethnicity, gender, and marital status seem to play a role.

Socioeconomic status

Socioeconomic status and level of education are linked, as low or no education can result in low-paid jobs. Association between the two can influence utilisation of health services for scarcity of financial resources is linked with low paid job (82). No evidence was found on the utilisation of MH services among migrant workers in Thailand and their socioeconomic status. Evidence related to the use of other health services was searched and used as proxy with the below findings.

Research revealed that among Myanmar, illegal migrant workers, with no education or less than primary education, the practice of purchasing drugs for self-treatment was linked with the inability to pay for health services (94). This finding found ground with a qualitative study among Cambodian and Myanmar migrant workers, which established a strong association between high education and HSU (100). And an additional study recognised the struggle of uneducated Myanmar migrant workers, to find a job that could eventually provide enough resources for basic needs, including health care (99).

The evidence indicates that the lower the level of education, the less likely it is for migrants to utilize health care. Illiteracy pushes migrant workers to accept low-paid employments that cannot support their health expenses and lack of education makes migrants purchase drugs from informal sellers, rather than seek help from a specialist.

Genetic factors

Research and development of new diagnostic tools have increased the chances of diagnosing inheritable diseases, influencing the need to utilize health services (82). Studies linking genetic factors to MH disorders were considered.

Recent studies have demonstrated links between depression and the genetic origin (105), confirming previous investigations of hereditary factors, contributing to the rise of depression (106,107).

With the development of new diagnostic tools and investment in science, it was possible to establish the link between depression and its genetic origin.

Immigrant status

Migrant workers' legal status can influence HSU (82).

In Thailand, legislators have provided several options for illegal migrant workers to legalize their status, but despite this, many are still working illegally, mainly because they cannot afford to pay for the procedure, with the consequence, among others, of not having the right to free healthcare (95,99). Subsequently, they prefer not to use public services for fear of being reported to the police, risking arrest, forced repatriation (93,95,99,108), house demolition (108), and also have to pay money to the police to avoid being sent to jail (93,99). Oftentimes employers of illegal migrants prevent workers from utilising public clinics and have access to health information for fears of being investigated by the law enforcement body (100).

In summary, evidence indicates that not being legally registered in Thailand, plays a major role in preventing migrant workers from seeking care, for fear of arrest,

deportation, and other penalties. Also, employers do not encourage illegal migrants to visit health centres in fear of been fined for giving jobs to unauthorized migrants.

Assimilation

Assimilation is the process migrants undergo when living and working in a new environment and through which they can be influenced or encouraged to utilize, or not, MH services (82). Articles on assimilation among migrant workers in Thailand in regard to MH were looked for, but no evidence was found. Conversely articles related to general health care were used.

A study conducted among Cambodian migrants revealed that, despite a positive opinion about Thai people, they don't mingle with them, with the consequence of not having the needed information to make the best use of services, including health care (100,109). A different research amid Cambodians and Myanmar migrant workers, shows that the latter have better chances to familiarize themselves with the host country's culture, as workers from Myanmar started migrating to Thailand before Cambodian did, thus having more understanding of the culture. This facilitates the exchange of information, including health-related ones. Conversely, Cambodian migrants who are less connected with native people will be employed in jobs with fewer chances to socialise with Thai colleagues (100).

The above indicates that assimilation can impact HSU. Adaptation to a new environment requires acquaintance with the local culture and this encourages exchange of information, including health-related ones, between locals and migrants.

Immigrant ethnic culture and Health beliefs

Norms, values, traditions, and beliefs are embedded in each of us, and they can influence HSU, as well as knowledge and attitude towards health-related matters, can be responsible to prevent or cause the rise of diseases and altering the perceived need for healthcare (82). Articles on MH services utilisation among migrant workers in Thailand and migrant ethnic culture and health beliefs were found, and additional studies on use of other health services were used for triangulation.

Migrant workers belonging to the Karen ethnic group (Myanmar) living in Thailand, declared that when they face problems related to stress (not sleeping well, thinking too much), they found relief among their cultural traditions, such as singing together, pray in groups and talking with people from the same ethnic group (110). In a qualitative study carried out in 2015 among 92 pregnant women of Myanmar origin (63 migrants and 29 refugees), participants were asked, among others, questions related to beliefs, traditions, and coping mechanisms for MH issues. Some of the interviewees mentioned that spirits were to blame for the development of MH disorders, in which case, attending a clinic would not help solve the problem (98).

A study on migrants from Myanmar, belonging to three different ethnic groups (Karen, Mon, and Burmese), was conducted in Thailand. Karen and Mon stated their strong beliefs in spirits. The former considers the rise of diseases originated by a spirit that the person might have offended. Accordingly, they can differentiate between a

sickness caused by a spirit from an ailment of natural cause. Ultimately, the origin of the disease determines the type of treatment the migrant will look for (94). Among Cambodians, community norms, values, and traditions are important, and the leaders' decisions are always followed. In a qualitative study Cambodian regular migrant workers explained that leaders could decide abruptly to move to a different area of the country, and by doing so they lose opportunity to use health services (109).

The evidence shows the importance that individuals, and communities yield to beliefs, norms, and traditions and how these can influence the utilisation of MH and health-related services and be responsible for the aggravation of diseases within an individual or community.

4.4 Contextual factors

Contextual factors are circumstances at public or societal level that move outside the person's control (82).

Government and Healthcare system's policy

Government arrangements, likewise, health policies, can influence the migrants utilisation of health services (82). The following elucidates government policies for migrant to access health services in Thailand.

Before 1972 all babies born on Thai territory, irrespective of the legal status of their parents, were given Thai nationality. With the "Immigration Act" of 1979 the government demanded deportation for all illegal migrants but decided not to execute the act given the pivotal role this category played in revamping the economy of the country (in 2010, 6.6% of gross domestic product resulted from the contribution of migrants' workers) (57,111). In 1999 the government established the "memoranda of understanding (MOUs)" between Thailand and migrant GMS country of origin, identifying the workers before entering the country (57). But the lengthy process to receive the document and the hight cost, discourages migrants to proceed (56) (39). The "national verification (NV) process", gives chance to irregular workers already present in the country to obtain a work permit (56,57). The procedure requires time and often workers need to ask help from a broker, making the process even more expensive for the majority (57). Both procedures provide health insurance, but only to workers employed in the formal sector. For illegal migrants who are working in the informal sector and are yet eager to receive a work permit and want to purchase an insurance health package, the government established the HICS (56,57). To be eligible to obtain the HICS health card, migrants must undergo a physical examination, where several tests are run. Additionally, the candidate should not suffer from mental diseases (57,92,93,112). If migrants turn positive to any of the medical screening, no work and residence permit is granted, and the candidate is deported back to his/her country of origin without been treated for the disease (57,92).

In a qualitative study among migrant workers in Thailand coming from Myanmar, LPDR and Cambodia, it was reported that some regional authorities, responsible for issuing the residency document upon completion of the medical check-up, refused to

accept the results of private clinics, creating confusion regarding law interpretation. Additionally, the lengthy and not easy process to comply with the regulation was described, as the main reason to enter Thailand illegally (112). The Policy does not specify who is responsible for the annual health card and necessary documentations fee, therefore oftentimes, the employer pays in advance for the charge and later subtracts the cost from the employers' salary, discouraging migrants to even initiate the process (113). Thai law only guarantees free emergency care for non-registered migrants (93,94), but for all other services (diagnostic, prescriptions) immigrants have to pay, thus influencing the decision to seek care (94). For those holding a regular working and resident permit, accessing healthcare, might be as difficult as for their illegal colleagues. According to 1999 law legislated by the “Registration Administration Bureau” all legal migrants can only access care in the province of residency (94,95), but oftentimes employers move the workers from a province to another, making it impossible for the staff to visit a health post (95). A survey sponsored by the WHO and IOM revealed that a limited number of migrants can visit public health centres, oftentimes due to the scarcity of government clinics in the area of residency (94). Lastly, a qualitative study amid Myanmar legal and illegal migrants (7 and 3 respectively) underlined the knowledge gap in subscribing to the health insurance card and the proper use of it, mainly for lack of clear information provided during the process of the medical check-up (103).

In 2006 WHO published a report on MH programs in Thailand stating that MH was part of Primary Health Care (PHC) since 2005. Further, the document provided a detailed description of the location of the total of 122 MH outpatient departments present in the country (25 in regional hospitals, 70 in provincial hospitals, 10 in university hospitals and 17 in Mental Health Hospitals), and PHC are excluded. Additionally, the assessments states that only clinics with the presence of a physician are allowed to assess and prescribe psychotic drugs. Mobile clinics and follow-up community care are not available in the country. Lastly, the document does not mention migrants nor mental health services for this group (114).

In summary, mandatory medical test whose results could cause the repatriation of the migrants, ambiguity on law interpretation (accepting investigations from private clinics, not clear indications on who is responsible for bearing the cost to regularize the migrant workers), lengthy procedure to receive the permit, restrictions on accessibility of health services for legal immigrants only in the area of residency, can hamper HSU for legal and illegal migrants alike. Additionally, evidence shows that MH programs in Thailand are not specifically designed for migrant workers and are not present at PHC level.

Socio-economic-political conditions

Socio-political conditions in one’s own country can influence the utilising of health services in another as well as tension among States, they could, directly and indirectly, affect the utilisation of health facilities (82). Evidence regarding socio-economic-

political conditions, influencing the utilisation of mental and health services among migrant workers in Thailand are presented below.

A Myanmar region bordering with Thailand (Karen State) is experiencing years of conflict between rebel and government troops. As a result, the health system in the area is unable to provide proper health and mental health care. For instance, the lack of proper TB facilities cannot guarantee diagnosis and treatment for patients. This spurs cross-border migrations to seek health care, either to non-governmental organisation clinics or government facilitates where migrants have to pay (97).

In a qualitative study, Cambodians admitted that they sometimes are victims of verbal and physical abuse by their employers because of tensions between Thailand and the migrant's county of origin, linked to past and current political events (war and border dispute). With fear of repercussion and job termination, Cambodian workers are afraid to request the employer permission to use services, including health, as explained by a member of the study: *"*They just kicked us out by saying we were Cambodian and could not live there anymore. At that time, I was paranoid about going out in public and felt that I was being stared at in hostile ways*"* (109).

The evidence found, demonstrates that political events accruing among migrant host and country of origin, can impact access to care in Thailand.

Context of emigration and health service utilisation in the homeland

This factors relates to the utilisation of services in one's country before migration and whether it influences the utilisation of services in the host nation (82). Articles discussing migrant workers' utilisation of MH services in relation with the context of emigrations were not found, conversely evidence on other health services were utilized as a proxy.

A study described well the situation of the health system across Myanmar states bordering with Thailand (Karen and Mon State) where, due to a protracted conflict between military and insurgents, the health facilities were not able to respond to population's mental and health needs (104). The same finding was underlined by a study that reported prevalence of TB among Myanmar migrants/refugees and Thai people residing in areas near the Myanmar-Thai border. The study showed that among the 1087 Myanmar TB positive citizens, 415 were cross-border patients, compared to 400 migrant workers and 248 refugees (97).

The results indicate that not having access to mental and health care in the country of origin does influence the use of health care in the host country.

Context of reception

Country and societal response, towards migrants, coupled with personal preconcept of the phenomenon of migration, can affect the immigrant's utilisation of health services (82).

A research on LPDR, Myanmar and Cambodia migrant workers, revealed that some employers keep document of the staff for “safety” measures, hindering workers from leaving their duty station even for medical reasons like visiting a clinic (95,113). A qualitative study of Cambodian foreign workers revealed that they are not always positively welcomed by Thai colleagues, because oftentimes they are seen as someone who stole the work that otherwise could be given to other Thai citizens, thus fearing abuse (109).

To summarize, migrants can be seen as a group that needs protection from Thai society, that perceives their presence as the cause of unemployment in the country. Actions taken by employers, to protect legal migrants (keep their documentation for safety reason), could impede access to care. Additionally, fear of being abused, prevents migrants from exposing themselves.

5.0 CHAPTER FIVE: DISCUSSION

This chapter reviews results and findings of the study that searches to describe factors influencing the utilisation of mental health services among migrant workers in Thailand, coming from the GMS. Little evidence was found, regarding migrant workers' specifically utilisation of MH services, while an inconclusive report on mental health activities in Thailand, shows the absence of programs designed to address migrant workers' wellbeing. Hence the decision to use as a proxy, studies from other health services (TB clinic, ANC and PNC centres, general health clinics, Hospitals).

From the studies emerged, that depression is the main MH issue affecting migrant workers in Thailand, followed by anxiety. It was not possible to establish the burden of these conditions with accuracy, as depression was found ranging from 4% to 69.7%, and anxiety from 3% to 44.9%. Among resources factors, little evidence was found in relation to determinants influencing migrant workers utilisation of MH services in Thailand. However, lack of financial means, and factors influencing access to care (language barrier, unfriendly staff, unfavourable working hours, long waiting time, poor infrastructure far to reach) clearly influence migrant workers' utilisation of other health services (TB, pregnancy-related clinic, and general health centres) in Thailand and outside GMS. Social resources seem to play an important role in encouraging migrant pregnant mothers to attend clinics and appears to provide emotional support to people suffering from MH disorder within and outside GMS. In contrast, homeland-based financial and social resources and transnational access to MH care were found to play a marginal role. Amid predisposing factors, there was hardly any evidence to relate to MH among migrant workers in Thailand. Conversely, utilisation of other health services (general health centres) among migrant workers in Thailand and outside GMS is influenced by demographic factors, immigrant status, socio-economic position. Immigrant's culture and health believes to some extend can impede utilisation of MH services, while assimilation seems to play a secondary role.

When analysing contextual factors regarding migrant workers' utilisation of MH services in Thailand, the evidence found shows the absence of programs designed for migrant workers mental wellbeing in the country. Looking at other services (Hospital and health clinics) in the context of Thailand and GMS, provided valuable information on the pivotal role that government policies play in influencing utilisation of health services among migrant workers while socio-economic-political conditions, context of reception, and context of emigration and health services utilisation in homeland show minor responsibility.

Among resources factors, little evidence was found in relation to the migrant workers' utilisation of mental health services in Thailand. Hence the decision to use, as a proxy, studies from other health services (TB and ANC-PNC clinic, general health services). Lack of financial means impedes migrants from purchasing health insurance (96), that covers health needs (57). Not benefitting from health insurance results, in having to pay for consultation, diagnostic test and prescriptions, hence discouraging migrants with lack of finance, from going to seek care (92–94,115). Financial means (resource

factors) interlinks with socio-economic status (predisposing factors), with immigrant status (predisposing factors) as well as government policy (contextual factors). Not having enough money could be the result of a low paid job that evidence links to poor education (socio-economic status) (99,116), hence the impossibility to pay for procedures to be legally registered (migrant status) that is the conditions to purchase health insurance package (government policy). Among Afghani migrants living in Australia, paying out-of-pocket was the main reason not to attend health centres (117). Additionally, Somali-Buthani-Iraqi female migrants living in the US, admitted that having little saving prevented them from travelling to an ANC clinic (118). Social resources also influence migrant workers utilisation of health services, in Thailand, as highlighted in several studies (95,98–100,115) and supported by new evidence among Turkish migrants women working in Sweden, suffering from mental disorders, that admitted talking to relatives and close friends was the first, and often the only, step to cure the disorder (119). Moreover among Latinos and Asian migrants in the United States, and African and South American migrant in Portugal, emerged that living close to the same ethnic group, favours the exchange of information including knowledge about the health care system (120,121). Access to care among migrant workers in Thailand is impeded by series of factors. Health personnel exerting bad behaviours towards patients for instance, demotivates migrants from visiting services (91). The same experience was reported by Somali-Buthani-Iraqi female migrants in the United States who stopped visiting health centres where the staff was not acting well with them (118). Clinic location also influences migrants' decision to visit the health post in Thailand (94,115,122), evidence supported by studies on African and South American migrants in Portugal (121) and among Afghani migrants in Australia (117), who reported unwillingness to attend far distance health centres. Unfavourable clinics' working hours also prevents migrants in Thailand from visiting the health centre (94,115). Similar results were found among African and South American migrants in Portugal (121). Also, long clinic waiting time, deters migrants in Thailand from visiting health posts (94,115). The same was found in Afghani migrants in Australia, and amid South America and African migrants in Portugal (117,121). Lastly, the impossibility to communicate with the Thai health workforce plays a pivotal role in preventing migrant workers from utilising health centres in Thailand and outside GMS. Studies among Iraqi-Somali-Buthani female migrants living in the United States, emphasised that the language barrier delayed access to ANC (118). Among Latinos and Asian migrants living in the United States (120), and amid Afghani migrants in Australia(117), the language-barrier was also an identified obstacle to utilise health services. Solutions to overcome this obstacle includes investing in health staff language education; pay incentives to bi-lingual health staff (120); including interpreter services in the insurance package. Clinic working hours to be extended to cover migrants needs, measures that could also work in favour of reducing patients waiting time.

Predisposing factors can also influence the decision to attend health centres, for general and child health, hence the proxy to MH services, among migrants in Thailand. Ethnicity can impact the health service utilisation as certain ethnic groups can endure

pain more than other (Karen, originally from Myanmar) (94). Among Myanmar migrant workers, females in the household play a central role in deciding whether to bring the child to the clinic and not the male (99). The presence of both parents among the migrant workers in Thailand, increases the chances for the child to be taken to health facilitates (92,100), finding supported by new evidence outside GMS suggesting that being married, positively influences the uptake of health services among adults, in African and South America migrants in Portugal (121). The migrants' status can significantly influence the utilisation of health services, as Thai legislation does not permit illegal migrations. Therefore, all irregular immigrants are under threat of arrest and repatriation at any time (57). The fear of been arrested, prevents illegal migrants in Thailand from utilising health centres (93,95,99,108), and the same was found amid Latinos and Asian migrants in the United States (120). Migrants from Africa and South America, living in Portugal, revealed that being illegal was preventing them from accessing the General Practitioner, through which they could get free health care (121). Migrant status relates to government policy (contextual factor), whose unclear composition, coupled with lengthy and expensive procedures, disfavour migrants from initiating the process. Amendments to current Immigration legislations will have positive effects on the migrant's status as well. Socio-economic factors can also influence HSU, as low education is linked to low paid jobs (99,116). This predisposing factor interacts with resources factor (financial resources) and contextual factor (government policy), for having not enough money (resulting from low paid job) prevents people from applying for legal status, because it is expensive. One solution to surmount a low paid job, could be to guarantee minimum wage for migrants. Although with limitations, as it can only be applied to those employed in formal sectors, ensuring the minimum wage can increase the household income (123). Lastly, the immigrant ethnic culture and health beliefs can hinder utilisation of health services. As explained by Karen (Myanmar ethnic group) migrant workers living in Thailand, who admitted praying and singing together to cure stress (110). Other Myanmar ethnic migrant workers groups, believe that mental illness is due to evil spirits, therefore going to a clinic would not help solving the problem (94,98). New evidence from outside GMS shows that among Somali migrants, living in the United States, reading holy scripture (Quran) was more important than visiting a clinician, adding that God was the one sending the disease and taking it back (124). Similar findings also emerged in a study among migrants living in Sweden and coming from Iraq, Palestine, Lebanon, and Egypt (125). Investing in health education interventions (distribution of pamphlet, TV-Radio message etc) helps to enhance migrants' health awareness.

Among contextual factors, government policies bear the greatest responsibility in preventing migrant workers from utilising health care in Thailand. Under the current Thai legislation, illegal migrants can regularize their status through the Memorandum of Understanding, providing a working permit to migrants before entering the country, and the National Verification Process, meant for illegal migrants already present in the country. Both procedures are intended for immigrants employed in formal jobs, (56,57). However, lengthy and expensive processes are the reason, expressed by

migrants, to prefer entering the country illegally (39,57,67). For illegal migrants, who rely on informal jobs, through the Health Insurance Card Scheme, they can receive a working permit and consequently purchase health insurance (56,57). The downside of it is that the mandatory medical screening, needed for migrants, to receive the working permit and to purchasing health insurance. Diseases like leprosy, elephantiasis, stage 3 syphilis, drug addiction, alcoholism, active TB and MH diseases are checked (57,92,93,112). If any of the tests turns positive, the person is deported, without receiving any treatment (57,92). Fear of repatriation, coupled with the cost of the process, encourages immigrant workers to choose not to regularize their status (57,111). Several studies underlined the unclearness of this policy, that, at the end, influences the migrants' decision to legalize their status. For instance, immigrants reported that some authorities decided not to recognize the medical results of private providers, blaming the ambiguity of the policy, regarding the use of private clinics (112). Additionally, migrant workers complained about the high cost of these procedures, that employers asked them to pay, as the policies do not clearly state who is responsible for it (113). In Thailand, people who are not covered by health insurance, can receive emergency care, free of charge, but have to pay for the prescription, diagnostic, and treatments, and this puts limits on the utilisation of health services, also in case of serious health threats (93,94). Lastly, according to Thai law, migrants eligible to receive free healthcare, need to be registered in the nearest clinic to her/his home address, preventing them from utilising other health centres. This law clearly does not consider mobile migrants, that for job reasons, are moved from one area to another by the employer, limiting their rights to health care (94,95). Lastly, health care system policy has also been identified as playing an important role in hindering migrant workers' utilisation of mental health services. A WHO report on Thailand's MH program, stated the presence of MH as an integral part of PHC, but data provided failed to demonstrate this. In the list of structures supporting MH, PHC is excluded. Further, the document mentions that mobile clinics and follow up community care are not available in the country. Lastly, the document does not mention migrants nor mental health services for this group (114).

Socio-economic-political conditions and context of emigration and health service utilisation, including mental health, in the homeland, can affect migrant workers utilisation of services utilisation in Thailand. Government policies interconnects with all the factors: resources as well as predisposing factors. With little money available, migrants cannot pay the cost of this lengthy and expensive procedures, meant to support their registration in the country. And without registration, illegal migrants can only get informal and low paid job. The ambiguity in which the policies have been written and the strict criteria that must be met for the application, are in fact deterrents for migrants to start the process. Policymakers should revise these policies by shortening the time and lowering the cost needed to receive the documents and clearly define employer and employees' responsibilities. Lastly, they should reconsider the exclusion of migrants who turn positive to the compulsory medical check-up for the work permit and review the clause of domicile, for legal migrants, to benefit from free

health care. Unclarity on the presence of MH services at PHC level and the lack of indication, in official report, of MH activities for migrant workers, suggests lack of programs to address mental wellbeing for this group.

In this time of the global pandemic, due to COVID-19, the migrants' health is even more endangered. As already explained, the lack of medical insurance and language barriers, among others, hinders HSU for migrant workers. Under normal conditions, MH issues among migrants, represent a critical load, that during the COVID-19 pandemic could worsen (126), as experienced by migrant workers in Malaysia (127). In countries where businesses were forced to close down and quarantine was imposed, migrant workers were more vulnerable than local people, due to overcrowded accommodations that increase the risk of spreading the infection, and job insecurity (127). To make the matter worse, health messages for the population are usually disseminated in the local language, that migrants often don't speak (126). Particularly at times like this, the health of the migrants should be guarded. Using the example of South Korea during the epidemic of the Middle East Respiratory Syndrome in 2015, in which health messages were sent out to the population, through phone messages (128), the government of Thailand could think of a similar solution, at least in areas where a connection is present. The same system could also be used to provide emotional support, using the migrants' own language.

The use of evidence-based studies about migrant workers' utilisation of other health services in Thailand, was used as a proxy, as little evidence was found regarding factors influencing the utilisation of MH services. The evidence gathered, suggests that many factors impede the migrants' utilisation of health services in Thailand, as already discussed. Migrant labours in Thailand is considered as the most important column, underpinning the country's economic growth, and the current number (4 million) will increase by an additional 4.7 million in the coming years (39,65). Investing in the migrants' health will not only improve their health, but will also tackle the issue of stigma, supporting integration, preserving global public health albeit making progress on social and economic front, as suggested by the Organisation for Economic Co-operation and Development on the economic impact of migration, who estimated that migrant workers could contribute to fill job vacancies up to 28%. Additionally, the study revealed that migrant workers play an important role in paying taxes and social contributions (129). Inclusive health strategies need to be developed, aiming first and foremost at those left behind. Migrants, that at present have limited access to health services and MH care, could benefit greatly from programs addressing basic health needs, including mental wellbeing. Healthy migrants are more receptive to learning and working, hence contributing to the structure of the society (130). In Italy, for instance, the government was able to provide equitable and affordable care to those left behind. Irregular migrants can obtain a card (with no name but only a number) through which they can access clinics and hospitals in any district of the country, receiving free health care, including preventive and maternity care with support of translators. Further, National legislation, clearly forbids health services to report to officials the presence of illegal migrants (131). By addressing the migrant

workers' mental and basic health needs, Thailand could set a precedent for other nations to follow, and feel even more proud knowing that through its example, no one will be left behind.

Yand and Hwant analytical framework helped to delve more into factors specific for migrants, hence appropriate for this study, for instance, the "immigrant status". On some occasions, two factors were merged. For example, "health beliefs" and "immigrant ethnic culture" influencing utilisation of MH services were found to have similarities, thus blend together. Equally true for "governmental policy" and "health care system", that merged provided a more comprehensive understanding of the problems. Although it was not possible to find evidence-based studies for all the sub factors (home-based financial and social resources, for instance), this framework provided invaluable support for writing this thesis, and I would recommend its applications to similar studies.

Study limitation

Lack of evidence-based studies on factors influencing utilisation of MH services among migrant workers in Thailand coming from the GMS, was the main challenge encountered during the writing of the thesis. Studies on the utilisation of health services other than mental health are available mainly for Myanmar migrants, little for the Cambodia and LPDR immigrants, few only regarding Vietnamese migrant and no evidence were found for Chines immigrants. Taking into account GMS central role for the economy of South-East-Asia and considering the essential role played by migrant workers, in sustaining Thailand economic growth, and the Sub region as a whole, more research, and studies among migrant workers and utilisation of MH services were expected to be found. The insufficient evidence gathered in support of the current government interventions for migrant workers' mental well-being in Thailand, came as a surprise.

6.0 CHAPTER SIX: CONCLUSION AND RECOMMENDATION

6.1 Conclusion

Little evidence is available, concerning factors influencing utilisations of mental health services among migrant workers in Thailand coming from the GMS, and this prompts to look at other health services (ANC-PMC and TB clinics, general health centres, hospitals), with results showing that several factors impede the migrant workers' utilisation of health services in Thailand. In addition, WHO unclear findings on mental health activities in Thailand, shows absence of programs designed to address migrant workers wellbeing.

Depression and anxiety have been found to be among the most important MH issues, affecting migrant workers in Thailand, with depression ranging from 4% to 69.7%, and anxiety from 3% to 44.9%. Resource factors play an important role in influencing utilisation of health services in Thailand among migrant workers, with financial resources, access to care and social resources being the most import one. Not having enough money prevents migrants from purchasing health insurance, apply for a working permit, pay for clinic bills, and travel to health posts. Access to care, among migrant workers in Thailand, is hampered by staff behaviour, clinic location and unfavourable working hours as well as language barrier. Lastly, social capital encourages the exchange of information as well as people support for health-related issues. Among predisposing factors hampering HSU in Thailand, demographic determinants play a side part, while immigrant status clearly has a more central role. Illegal migration is not allowed in Thailand and irregular migrants face arrest and deportation, hence visiting health post could potentially expose them to sanctions. Additionally, being illegal, prevents migrants from purchasing health insurance. Socio-economic factors influence utilisation of health services as low-wage jobs, usually offered to migrants, are mostly due to their low education, and as a result, don't provide enough financial resources. Finally, the immigrants' ethnic cultural and health beliefs impact utilisation of mental and health services, as migrant workers often have strong cultural traditions, values, and practices, that they prefer to use, rather than visiting a health professional. To conclude, among contextual factors, government and health system policies greatly influence HSU among migrant workers in Thailand. Thai government established several procedures to legalize the migrants' status and let them obtain a working permit, that through tax payment, guarantees migrants' coverage of health care. But the policies' ambiguous interpretation, expensive to afford, needing time to be approved, and having strict criteria to comply with (mandatory negative medical check-up), discourages immigrants from applying. Additionally, migrant workers in possession of work permits, can only be registered in the health centre where they reside, creating difficulties for migrants relocated to other areas by their employers, to use health services. Lastly, the current regulation permits only emergency care, to be provided free of charge to those not covered by health insurance, but remaining costs (prescription, investigations, and drugs) must be paid by patients, thus discouraging migrant workers from attending clinics, even for life-

saving conditions. Report's unclarity on the existence of MH activities at PHC level and lack of evidence on the presence of MH programs for migrant workers in the country, suggests absence of such activities in support of this group mental wellbeing.

With a UHCSCI of 85% (on a scale 0%-100%), Thailand has one of the highest indexes in the region, and in 2019 the country declared that 98% of its population was covered by the health insurance. Nonetheless, findings in this study suggests that not everyone in the country, can enjoy promoting and preventive care, treatment, rehabilitative and palliative care, without suffering financial destitution. In fact, the migrant workers' utilisation of mental and health care services is seriously hampered by several factors, addressed in this study. While no one can deny the institutions' efforts to work jointly toward 2030 SGDs, more work needs to be done to promote inclusive policies, aiming primarily at leaving no one behind.

6.2 Recommendations

To bridge the gap of the little evidence-based studies available on the factors impacting utilisation of mental health services among migrant workers coming from the GMS, is pivotal to advocate more research in this domain.

Meanwhile, the following recommendations will help in supporting migrant workers affected by MH disorders and to improve factors, hampering utilisation of mental and health services. First and foremost, to bring changes to the current status quo is pivotal to have the support of the policymakers, and in this regard, they need to be made aware of the current struggles migrant workers are facing, utilizing mental and health services. Once the knowledge gap is filled, we could expect support from them. Changing current policies and passing new decrees can take time, while the issue of migrants, not utilizing MH services continues. To solve this pressing matter and to fill the vacuum until more long-term solutions are worked out, MoPH needs to engage with private-not-for-profit organisations working on mental health. This will provide support to the migrant workers' mental wellbeing as well as to promote access to care. At the same time, at community level, a team of Community Based Health Workers should be formed and trained, able to provide mental health counselling according to individual/community needs. As suggested by the WHO, community-bases services help in early detection and intervention, limiting issues related to undiagnosed disease and stigma in the community (132).

The MoPH needs to take actions in support of allocation resources for MH programs to be enhanced at PHC level. Planning trainings for the clinic health staff on diagnosing and treatment for MH disorders (to be repeated on a regular base) and on the migrants' rights to healthcare, as well as stigma-free health facility training, to create a more inclusive environment for migrant workers to attend clinics. Additionally, it needs to develop and disseminate key messages about MH disorders and information, on where to get help through posters, pamphlets, and social media (radio, tv. mobile messages) in the migrants' own language. Simultaneously, policymakers will need to work on reviewing ambiguous policies in relation to work permits, the purchase of the health insurance package, and other issues related to the migrant workers' right to

healthcare, including mental health. Lastly, policymakers need to address the issue of the migrant workers' minimum wage and daily workers' wage, as it brings many inequities, impeding HSU among immigrant workers. To overcome the problem of the language barrier, between migrant and Thai health staff, several initiatives could help: investing in health staff language training, providing incentives to staff who speak more than one language and organise community-based Thai speaking volunteers.

6.2.1 Government level

6.2.1.1 MoPH

- Allocate financial resources for MH project aiming at migrant workers at Primary Health Care level; training health staff on diagnose and treatment for MH disorders (to be repeated on a regular base); develop protocols and policies on MH issues.
- To disseminate information among health staff on the migrant's right to healthcare and organise "stigma-free health facility training" for health staff, to create a more inclusive environment for migrant workers to attend.
- To include an interpreter service in the health insurance package, incentivise bi-lingual education for health staff, and offer extra incentive to staff who can speak more than one language to overcome the migrants' language barrier.
- To develop and disseminate key messages about MH disorders and information on where to get help, through posters, pamphlets, and social media (radio, tv. mobile messages) in the migrants' own language.
- Reschedule clinic working time, to allow migrant workers to attend health posts in the late afternoon or evening. This measure will also help to reduce the patients' waiting time.
  To include MH interventions among the basic benefit package of the insurance card schemes.

6.2.1.2 Ministry of Labour

- To guarantee a standardized daily worker's wage and minimum wage for migrants, that will help to reduce financial barriers to utilize mental and health services.
- Clarify policies ambiguities regarding accepting private clinic medical check-up results for HICS applicants and who is responsible for paying the cost for the application of MOU, NV and HICS.
- Abolish the fee for receiving a work permit and shorten the time to receive it.

6.2.1.3 Ministry of interior

- Remove from current legislation the repatriation for migrants whose medical tests are positive when applying for HICS and introduce free treatment for those who are positive of diseases.
- Change the policy that enforces utilisation of health services among migrant workers, only in the area of domicile.

6.2.2 Research institutions

- To organize qualitative research to describe factors hampering the migrant workers' utilisation of mental health services, which results will be used to prioritise interventions and to show policy makers the urgency to act, with emphasis on Chinese and Vietnamese migrant workers that currently are not represented in may studies.
- To organize quantitative research, among migrant workers, to determine burden of mental health disorders.

6.2.3 Development partners

- Engage with private-not-for-profit organisations to work in communities where migrant workers live and work, to deliver specialized MH support and promote migrant workers' access to care.

6.2.4 Community

- Organize a Community Based Health Workers team, among migrant workers, able to provide MH counselling, and support according to individual/community needs, using the advantage of the migrants' own language knowledge.
- To establish community-based Thai-speaking volunteers, to support migrants with difficulties in speaking Thai, to attend health clinics.

References

1. Meisel A. Access to care. J N J Dent Assoc [Internet]. 2010 [cited 2021 Aug 10]; Available from: https://www.ahrq.gov/topics/access-care.html
2. American Psychological Assosiation. Anxiety [Internet]. [cited 2021 Aug 8]. Available from: https://www.apa.org/topics/anxiety
3. Portal MD. Key Migration Terms. Gloss Migr [Internet]. 2011 [cited 2021 Jul 30]; Available from: https://www.iom.int/key-migration-terms
4. R. Parekh. What is mental illness. Am Psychiatr Assoc [Internet]. 2021 [cited 2021 Aug 8]; Available from: https://www.psychiatry.org/patients-families/what-is-mental-illness
5. Disability-adjusted life years (DALYs) [Internet]. [cited 2021 Jul 22]. Available from: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158
6. IOM. Glossary on Migration [Internet]. 2011. Available from: https://www.corteidh.or.cr/sitios/observaciones/11/anexo5.pdf
7. Migrant workers | Ethical Trading Initiative [Internet]. [cited 2021 Jul 29]. Available from: https://www.ethicaltrade.org/issues/migrant-workers
8. IOM. Who is a migrant? | International Organization for Migration [Internet]. 2018 [cited 2021 Jul 30]. Available from: https://www.iom.int/who-is-a-migrant
9. United Nations. Millennium Development Goals | MDG Fund [Internet]. [cited 2021 Aug 8]. Available from: http://www.mdgfund.org/node/922
10. American Psychiatric Association. What Is PTSD? [Internet]. [cited 2021 Aug 8]. Available from: https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd
11. UN Global Compacts on Refugees and Migration. Irregular migration and regular pathways, including decent work, labour mobility, recognition of skills. 2017.
12. American Psychological Assosiation. Stress [Internet]. [cited 2021 Aug 8]. Available from: https://www.apa.org/topics/stress
13. UN. THE 17 GOALS | Sustainable Development [Internet]. Department of Economic and Social Affairs. 2020 [cited 2021 Mar 18]. Available from: https://sdgs.un.org/goals
14. World Health Organisation. WHO | Sustainable Development Goal 3: Health [Internet]. [cited 2021 May 28]. Available from: https://www.who.int/topics/sustainable-development-goals/targets/en/
15. Box TCT. Determining Service Utilization [Internet]. Community Tool Box. 2018 [cited 2021 Aug 10]. Available from: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/determine-service-utilization/main
16. Country Profile – Royal Thai Embassy [Internet]. [cited 2021 Jun 9]. Available from: http://newdelhi.thaiembassy.org/en/about-thailand/country-profile/
17. United Nations Geoscheme [Internet]. [cited 2021 Jun 9]. Available from: https://unstats.un.org/unsd/methodology/m49/
18. Facts About Myanmar [Internet]. [cited 2021 Jun 10]. Available from: http://www.myanmar-embassy-tokyo.net/about.htm
19. Geography of Laos [Internet]. [cited 2021 Jun 10]. Available from:

http://www.na.gov.la/files/appf17/geography.html

20. Land boundaries - The World Factbook [Internet]. [cited 2021 Jun 10]. Available from: https://www.cia.gov/the-world-factbook/field/land-boundaries/

21. Thailand Population (2021) - Worldometer [Internet]. 2021. [cited 2021 Jun 9]. Available from: https://www.worldometers.info/world-population/thailand-population/

22. The World Bank. Population, total - Thailand | Data [Internet]. [cited 2021 Jun 10]. Available from: https://data.worldbank.org/indicator/SP.POP.TOTL?locations=TH

23. The World Bank. Literacy rate, adult - Thailand | Data [Internet]. 2018 [cited 2021 Jun 24]. Available from: https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS?locations=TH

24. The World Bank. Unemployment, rate - Thailand | Data [Internet]. 2018 [cited 2021 Jun 24]. Available from: https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS?end=2018&locations=TH&start=1991

25. Sein Than Tun, Phone M, Nilar T, Htay W, San AS, Than S. The Republic of the Union of Myanmar Health System Review. 2014.

26. The World Bank Group. Thailand: Overview [Internet]. The World Bank: Working for a World Free of Poverty. 2021 [cited 2021 Jun 10]. Available from: https://www.worldbank.org/en/country/thailand/overview

27. WHO. Heatlh System Review , The Kingdom of Thailand. WHO. 2015.

28. Section UC. Thailand | Geospatial, location information for a better world [Internet]. [cited 2021 Jun 10]. Available from: https://www.un.org/geospatial/content/thailand

29. WHO. Global Health Expenditure Database [Internet]. [cited 2021 Jun 10]. Available from: https://apps.who.int/nha/database/ViewData/Indicators/en

30. The World Bank. Out-of-pocket expenditure (% of current health expenditure) - Myanmar, Cambodia, Lao PDR, Thailand, Vietnam, China | Data [Internet]. [cited 2021 Jun 10]. Available from: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=MM-KH-LA-TH-VN-CN

31. UNICEF. Thailand - Demographics, Health & Infant Mortality - UNICEF DATA [Internet]. [cited 2021 Jun 10]. Available from: https://data.unicef.org/country/tha/

32. WHO. WHO - NCDs country profile - Thailand [Internet]. 2016 [cited 2021 Jul 22]. Available from: https://www.who.int/nmh/countries/tha_en.pdf

33. WHO. Thailand [Internet]. 2019 [cited 2021 Jun 10]. Available from: https://www.who.int/countries/tha/

34. Thailand - life expectancy at birth by gender 2009-2019 | Statista [Internet]. [cited 2021 Jul 22]. Available from: https://www.statista.com/statistics/974709/life-expectancy-at-birth-in-thailand-by-gender/

35. Asiand Develpment Bank - GMS. G r e at e r M e k o n g S u b r e g i o n. 2018.

36. Greater Mekong Subregion | (GMS) [Internet]. [cited 2021 May 10]. Available from: https://greatermekong.org/about

37. Subregion GM. Greater Mekong Subregion (GMS). [cited 2021 May 7]; Available from: https://www.greatermekong.org/stats/index-static.php

38. U.S. Census Bureau. Current Population [Internet]. U.S. Census Bureau. 2019 [cited 2021 May 7]. Available from: https://www.census.gov/popclock/print.php?component=counter

39. IOM. Thailand Migration Report 2019 | IOM Thailand [Internet]. 2019 [cited 2021 Aug 1]. Available from: https://thailand.iom.int/thailand-migration-report-2019-0

40. Greater Mekong Subregion - March 2019 [Internet]. [cited 2021 Jun 24]. Available from: https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0008302

41. Marie-Paule Kieny DBE. WHO EMRO _ Universal health coverage [Internet]. World Health Organization; 2013 [cited 2021 May 7]. p. 305–6. Available from: http://www.emro.who.int/emhj-vol-19-2013/4/universal-health-coverage.html

42. World Health Organisation. Universal Health Coverage [Internet]. [cited 2021 May 7]. Available from: https://www.who.int/healthsystems/universal_health_coverage/en/

43. uhc International Health Partnership. Universal Health Coverage Advocay Guide [Internet]. 2018 [cited 2021 Mar 18]. Available from: https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Advocacy/UHC_Advocacy_Guide_March_2018_final.pdf

44. Network JL. THE GLOBAL PUSH FOR UNIVERSAL HEALTH COVERAGE [Internet]. 2014 [cited 2021 May 7]. Available from: https://www.who.int/health_financing/GlobalPushforUHC_final_11Jul14-1.pdf

45. Kieny MP, Bekedam H, Dovlo D, Fitzgerald J, Habicht J, Harrison G, et al. Strengthening health systems for universal health coverage and sustainable development goals. Bull World Health Organ. 2017;95(7):537–9.

46. UN General Assembly. Universal Declaration of Human Rights Preamble [Internet]. United Nations Declaration of Human Rights. 1948 [cited 2021 Mar 18]. Available from: https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

47. UNDP. What does it Mean to Leave No One Behind? United Nations Development Programme. 2018.

48. Assembly TG. UN General Assembly Resolution 74/2. In: International Organization. 2019. p. 1/12-12/12.

49. Assembly TG. UN General Assembly Resolution 67/81. Mar Policy. 2012;

50. Roser M, Ortiz-Ospina E. Goal 3: Good Health and Well-Being - SDG Tracker [Internet]. SDG Tracker. 2018 [cited 2021 Mar 18]. Available from: https://sdg-tracker.org/good-health

51. Chan M. Making fair choices on the path to universal health coverage. Heal Syst Reform. 2014;1.

52. WHO. WHO | Universal coverage - three dimensions. WHO [Internet]. 2015 [cited 2021 May 8]; Available from: https://www.who.int/health_financing/strategy/dimensions/en/

53. WHO, The World Bank. Tracking Universal Health Coverage: 2017 Global Monitoring Report. World Health Organisation. 2017. 88 p.

54. Office NHS. Thailand, National Health Security Act, 202 [Internet]. 2002. Available from: https://eng.nhso.go.th/assets/portals/1/files/NHS ACT_book_revised Apr5.pdf

55. Akmaliyah M. Thailand’s Univesal Health Coverage Scheme: Achievements and Challenges. Health Insurance System Research Office. 2013.

56. Hanvoravongchai P. Health financing reform in Thailand: toward universal coverage under fiscal constraints. World Bank. 2013;(20):1–36.

57. Suphanchaimat R, Putthasri W, Prakongsai P, Tangcharoensathien V. Evolution and complexity of government policies to protect the health of undocumented/illegal migrants in Thailand – The unsolved challenges. Risk Manag Healthc Policy. 2017;10:49–62.

58. Sumriddetchkajorn K, Shimazaki K, Ono T, Kusaba T, Sato K, Kobayashi N. Universal health coverage and primary care, Thailand. Bull World Health Organ. 2019;97(6):415–22.

59. Van Minh H, Pocock NS, Chaiyakunapruk N, Chhorvann C, Duc HA, Hanvoravongchai P, et al. Progress toward universal health coverage in ASEAN. Glob Health Action. 2014;7(1):1–12.

60. Witthayapipopsakul W, Kulthanmanusorn A, Vongmongkol V, Viriyathorn S, Wanwong Y, Tangcharoensathien V. Achieving the targets for universal health coverage: how is Thailand monitoring progress? WHO South-East Asia J public Heal. 2019;8(1):10–7.

61. WHO. Monitoring progress on UHC in South East Regioins - 2018 Update. 2018.

62. IOM. World Migration Report 2020. International Organization for Migration. 2020. 1–498 p.

63. United Nations. International migrant. Dep Econ Soc Aff [Internet]. 2019 [cited 2021 May 14];2019(4):1–4. Available from: https://www.un.org/development/desa/pd/themes/international-migration

64. The World Bank. Out-of-pocket expenditure - Data [Internet]. [cited 2021 May 7]. Available from: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?name_desc=false

65. International Organization for Migration. Regional Strategy for Asia and the Pacific 2012-2015. 2015;

66. Migration Context | IOM Thailand [Internet]. [cited 2021 May 9]. Available from: https://thailand.iom.int/migration-context

67. Harkins B. Thailand Migration Report 2019. Organization. 2019;97.

68. IOM W and. − THE WAY FORWARD Report of a global consultation. 2010;(March):119.

69. Pavli A, Maltezou H. Health problems of newly arrived migrants and refugees in Europe. J Travel Med. 2017;24(4):1–8.

70. Abbas M, Aloudat T, Bartolomei J, Carballo M, Durieux-Paillard S, Gabus L, et al. Migrant and refugee populations: A public health and policy perspective on a continuing global crisis. Antimicrob Resist Infect Control. 2018;7(1):1–11.

71. Ritchie H, Roser M. Mental Health - Our World in Data [Internet]. Mental Health. 2020 [cited 2021 May 14]. Available from: https://ourworldindata.org/mental-health

72. WHO. Mental health. Who [Internet]. [cited 2021 May 13]; Available from: https://www.who.int/westernpacific/health-topics/mental-health

73. MHIN. Linking Mental Health & NCD Priorities | Mental Health Innovation Network [Internet]. 2018 [cited 2021 May 13]. Available from: https://www.mhinnovation.net/resources/linking-mental-health-ncd-priorities

74. Institute for Health Metrics and Evaluation. GBD Compare | IHME Viz Hub [Internet]. Global Burden of Disease. 2019 [cited 2021 May 14]. p. 1. Available from: https://vizhub.healthdata.org/gbd-compare/

75. Kesornsri S, Sitthimongkol Y, Punpuing S, Vongsirimas N, Hegadoren KM. Mental health and related factors among migrants from Myanmar in Thailand. J Popul Soc Stud. 2019;27(2):124–38.

76. Meyer SR, Robinson WC, Chhim S, Bass JK. Labor migration and mental health in cambodia: A qualitative study. J Nerv Ment Dis. 2014;202(3):200–8.

77. Allison Abbott. The troubled minds of migrants [Internet]. 2016 [cited 2021 May 14]. Available from: https://www.hafricah.net/wp-content/uploads/2016/11/nature-migrants.pdf

78. Foo SQ, Tam WW, Ho CS, Tran BX, Nguyen LH, McIntyre RS, et al. Prevalence of depression among migrants: A systematic review and meta-analysis. Int J Environ Res Public Health. 2018;15(9).

79. IOM - MoPH Thailand. Healthy migrants, heatlhy Thailand: a migrant health program model. 2009.

80. Kirmayer LJ, Weinfeld M, Burgos G, Du Fort GG, Lasry JC, Young A. Use of health care services for psychological distress by immigrants in an urban multicultural milieu. Can J Psychiatry. 2007;52(5):295–304.

81. Chen AW, Kazanjian A, Wong H, Reid RJ. Differences in mental health diagnoses between recent Chinese immigrants and a comparison population in British Columbia. Healthc Policy. 2009;5(2):40–50.

82. Yang PQ, Hwang SH. Explaining Immigrant Health Service Utilization: A Theoretical Framework. SAGE Open. 2016 May 8;6(2).

83. Guo S, Liu M, Chong SY, Zendarski N, Molloy C, Quach J, et al. Health service utilisation and unmet healthcare needs of Australian children from immigrant families: A population-based cohort study. Heal Soc Care Community. 2020;28(6).

84. Yi J, Lee I. Factors affecting unmet healthcare needs of working married immigrant women in South Korea. J Korean Acad Community Heal Nurs. 2018;29(1):41–53.

85. Meyer SR, Decker MR, Tol WA, Abshir N, Mar AA, Robinson WC. Workplace and security stressors and mental health among migrant workers on the Thailand–Myanmar border. Soc Psychiatry Psychiatr Epidemiol. 2016;51(5):713–23.

86. Laohasiriwong W, Chamroen P, Samphors S, Rachutorn T, S. Dewey R, Pisey V. Mental health status and quality of life among Cambodian migrant workers in Thailand. F1000Research. 2020;9:1138.

87. Pocock NS, Tadee R, Tharawan K, Rongrongmuang W, Dickson B, Suos S, et al. “Because if we talk about health issues first, it is easier to talk about human trafficking”; findings from a mixed methods study on health needs and service provision among migrant and trafficked fishermen in the Mekong. Global Health. 2018;14(1):1–19.

88. Nilvarangkul K, Rungreangkulkij S, Wongprom J. Perception of stress in Laotian migrant workers in Thailand. J Immigr Minor Heal. 2010;12(5):678–82.

89. Mental and Emotional Impact of Stress [Internet]. [cited 2021 Jun 30]. Available from: https://www.mentalhelp.net/stress/emotional-impact/

90. Stress | Mental Health Foundation [Internet]. 26 Marh. 2021 [cited 2021 Jun 30].

Available from: https://www.mentalhealth.org.uk/a-to-z/s/stress

91. Kiss L, Pocock NS, Naisanguansri V, Suos S, Dickson B, Thuy D, et al. Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: An observational cross-sectional study. Lancet Glob Heal. 2015;3(3):e154–61.

92. Laohasiriwong W, Khongthanachayopit S. Accessibility to health services among migrant workers in the Northeast of Thailand. F1000Research. 2017;6(0):1–10.

93. Tschirhart N, Nosten F, Foster AM. Access to free or low-cost tuberculosis treatment for migrants and refugees along the Thailand-Myanmar border in Tak province, Thailand. Int J Equity Health. 2016;15(1):1–12.

94. Isarabhakdi P. Meeting at the crossroads: Myanmar migrants and their use of Thai health care services. Asian Pacific Migr J. 2004;13(1):107–26.

95. WHO-IOM. Financing Health care for migrants: a case study from Thailand. 2009.

96. Thetkathuek A, Jaidee W, Jaidee P. Access to Health Care by Migrant Farm Workers on Fruit Plantations in Eastern Thailand. J Agromedicine. 2017;22(3):189–99.

97. Hemhongsa P, Tasaneeyapan T, Swaddiwudhipong W, Danyuttapolchai J, Pisuttakoon K, Rienthong S, et al. TB, HIV-associated TB and multidrug-resistant TB on Thailand's border with Myanmar, 2006-2007. Trop Med Int Heal. 2008;13(10):1288–96.

98. Fellmeth G, Plugge E, Paw KM, Charunwatthana P, Nosten F, McGready R. Pregnant migrant and refugee women's perceptions of mental illness on the Thai-Myanmar border: a qualitative study. BMC Pregnancy Childbirth. 2015;15(1):1–11.

99. Khirikoekkong N, Jatupornpimol N, Nosten S, Asarath SA, Hanboonkunupakarn B, McGready R, et al. Research ethics in context: Understanding the vulnerabilities, agency and resourcefulness of research participants living along the Thai–Myanmar border. Int Health. 2020;12(6):551–9.

100. Holumyong C, Ford K, Sajjanand S, Chamratrithirong A. The Access to Antenatal and Postpartum Care Services of Migrant Workers in the Greater Mekong Subregion: The Role of Acculturative Stress and Social Support. J Pregnancy. 2018;2018.

101. Fellmeth G, Oo MM, Lay B, McGready R. Paired suicide in a young refugee couple on the Thai-Myanmar border. BMJ Case Rep. 2016;2016:10–3.

102. Lingam R. Asylum seekers and Refugees in Australia An assessment of the mental health beliefs and needs of refugees from Burma. 2003;148–62.

103. Srisai P, Phaiyarom M, Suphanchaimat R. Perspectives of migrants and employers on the national insurance policy (Health insurance card scheme) for migrants: A case study in Ranong, Thailand. Risk Manag Healthc Policy. 2020;13:2227–38.

104. Lee TJ, Mullany LC, Richards AK, Kuiper HK, Maung C, Beyrer C. Mortality rates in conflict zones in Karen, Karenni, and Mon states in eastern Burma. Trop Med Int Heal. 2006;11(7):1119–27.

105. Ormel J, Hartman CA, Snieder H. The genetics of depression: successful genome-wide association studies introduce new challenges. Transl Psychiatry. 2019;9(1).

106. Shadrina M, Bondarenko EA, Slominsky PA. Genetics factors in major depression disease. Front Psychiatry. 2018;9(JUL):1–18.

107. Lohoff FW. Overview of the genetics of major depressive disorder. Curr Psychiatry

Rep. 2010;12(6):539–46.

108. Photikanit K, Sirasoonthorn P, Aneksuk B. Thai State, Health Discourses and Subalternity Among Migrant Workers: Lesson Learned From Thailand. Int J Soc Sci. 2018;4(3):360–81.

109. Chaisuparakul S. Life and Community of Cambodian Migrant Workers in Thai Society. J Popul Soc Stud. 2015;23(1):2–16.

110. Cardozo BL, Talley L, Burton A, Crawford C. Karenni refugees living in Thai-Burmese border camps: Traumatic experiences, mental health outcomes, and social functioning. Soc Sci Med. 2004;58(12):2637–44.

111. Kuanruthai Siripatthanakosol. TRIANGLE in ASEAN Quarterly Briefing Note on Thailand's Migrants. 2019;(September).

112. Kunpeuk W, Teekasap P, Kosiyaporn H, Julchoo S, Phaiyarom M, Sinam P, et al. Understanding the problem of access to public health insurance schemes among cross-border migrants in thailand through systems thinking. Int J Environ Res Public Health. 2020;17(14):1–19.

113. Suphanchaimat R, Pudpong N, Tangcharoensathien V. Extreme exploitation in Southeast Asia waters: Challenges in progressing towards universal health coverage for migrant workers. PLoS Med. 2017;14(11):1–6.

114. World Health Organisation & Ministry of Health and Population T. WHO-AIMS Report on Mental Heatlh System in Thailand. 2006.

115. Naing SHH, Isaramalai SA, Sukmag P. Policy Literacy, Barriers, and Gender Impact on Accessibility to Healthcare Services under Compulsory Migrant Health Insurance among Myanmar Migrant Workers in Thailand. J Environ Public Health. 2020;2020(1992).

116. ILO. The migrant pay gap: Understanding wage differences between migrants and nationals. 2020. 102 p.

117. Cheng IH, Vasi S, Wahidi S, Russell G. Rites of passage: Improving refugee access to general practice services. Aust Fam Physician. 2015;44(7):503–7.

118. Kentoffio K, Berkowitz SA, Atlas SJ, Oo SA, Percac-Lima S. Use of maternal health services: comparing refugee, immigrant and US-born populations. Matern Child Health J. 2016;20(12):2494–501.

119. Bäärnhielm S, Ekblad S. Turkish migrant women encountering health care in Stockholm: A qualitative study of somatization and illness meaning. Cult Med Psychiatry. 2000;24(4):431–52.

120. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: Sources of vulnerability. Health Aff. 2007;26(5):1258–68.

121. Linhas R, Oliveira O, Meireles P, Oliveira P, de Melo MB, Lourenço J, et al. Immigrants' access to health care: Problems identified in a high-risk tuberculosis population. Pulmonology. 2019;25(1):32–9.

122. Tschirhart N, Jiraporncharoen W, Angkurawaranon C, Hashmi A, Nosten S, McGready R, et al. Choosing where to give birth: Factors influencing migrant women's decision making in two regions of Thailand. PLoS One [Internet]. 2020;15(4):1–13. Available from: http://dx.doi.org/10.1371/journal.pone.0230407

123. Gindling TH. Does increasing the minimum wage reduce poverty in developing countries? IZA World Labor. 2018;(May 2014):1–10.

124. Clarkson Freeman PA, Penney DS, Bettmann JE, Lecy N. The Intersection of Health Beliefs and Religion Among Somali Refugees: A Qualitative Study. J Relig Spiritual Soc Work. 2013;32(1):1–13.

125. Hjelm K, Bard K, Nyberg P, Apelqvist J. Religious and cultural distance in beliefs about health and illness in women with diabetes mellitus of different origin living in Sweden. Int J Nurs Stud. 2003;40(6):627–43.

126. Liem A, Wang C, Wariyanti Y, Latkin CA, Hall BJ. The neglected health of international migrant workers in the COVID-19 epidemic. The Lancet Psychiatry [Internet]. 2020;7(4):e20. Available from: http://dx.doi.org/10.1016/S2215-0366(20)30076-6

127. Wahab A. The outbreak of Covid-19 in Malaysia: Pushing migrant workers at the margin. Soc Sci Humanit Open [Internet]. 2020;2(1):100073. Available from: https://doi.org/10.1016/j.ssaho.2020.100073

128. Park HJ, Lee BJ. The Role of Social Work for Foreign Residents in an Epidemic: The MERS Crisis in the Republic of Korea. Soc Work Public Health. 2016;31(7):656–64.

129. OECD. Is migration good for the economy? Migr Policy Debates. 2014;(May):1–4.

130. Grondin D. Well-managed migrant's health benefits all. Bull World Health Organ. 2004;82(8):561.

131. World Health Organization. Health of refugees and migrants: Regional situation analysis, practices, experiences, lessons learned and ways forward. WHO African Reg. 2018;28.

132. W.H.O. The world health report 2001 — Mental health: new understanding, new hope. Bull World Health Organ. 2001;79(11):1085–1085.

133. American Psychiatric Association. DSM–5 Manual. Am Psychiatr Assoc. 2013;9.

Appendix

Annex 1: Characteristics of the Health Insurance Card Scheme for migrants (57)

Card	Premium	Length of coverage	Beneficiaries	Beginning from	Benefit package	Legal basis
Health Insurance Card for migrants	2,200 Baht + 500 Baht for health check	1 year	All non-Thai populations, except for tourists, and Caucasian foreigners	January 15, 2013	Outpatient, inpatient, and health promotion, disease prevention services (including HIV/AIDS treatment, and other high-cost care; excluding renal replacement therapy for chronic renal failure and treatment for psychosis and drug dependence)	The Cabinet Resolution on January 15, 2013
Health Insurance Card for migrant children	365 Baht	1 year	Migrant child aged <7 years	January 15, 2013		
Health Insurance Card for migrant workers	1,600 Baht + 500 Baht for health check	1 year	Migrants who registered with the One Stop Service by October 31, 2014	July 7, 2014	Outpatient, inpatient, and health promotion, disease prevention services (including HIV/AIDS treatment, and other high-cost care; excluding renal replacement therapy for chronic renal failure and treatment for psychosis and drug dependence)	The Order of the National Council for Peace and Order (NCPO) in 2014

Annex 2: List of Neurodevelopmental Disorders (133)

Intellectual Disabilities	Intellectual Disability (Intellectual Developmental Disorder) Global Developmental Delay Unspecified Intellectual Disability (Intellectual Developmental Disorder)
Communication Disorders	Language Disorder Speech Sound Disorder (previously Phonological Disorder) Childhood-Onset Fluency Disorder (Stuttering) Social (Pragmatic) Communication Disorder Unspecified Communication Disorder
Autism Spectrum Disorder	Autism Spectrum Disorder
Attention-Deficit/Hyperactivity Disorder	Attention-Deficit/Hyperactivity Disorder Other Specified Attention-Deficit/Hyperactivity Disorder Unspecified Attention-Deficit/Hyperactivity Disorder
Specific Learning Disorder	Specific Learning Disorder
Motor Disorders	Developmental Coordination Disorder Stereotypic Movement Disorder *Tic Disorders* Tourette's Disorder Persistent (Chronic) Motor or Vocal Tic Disorder Provisional Tic Disorder Other Specified Tic Disorder Unspecified Tic Disorder

Other Neurodevelopmental Disorders	Other Specified Neurodevelopmental Disorder Unspecified Neurodevelopmental Disorder
Schizophrenia Spectrum and Other Psychotic Disorders	Schizotypal (Personality) Disorder Delusional Disorder Brief Psychotic Disorder Schizophreniform Disorder Schizophrenia Schizoaffective Disorder Substance/Medication-Induced Psychotic Disorder Psychotic Disorder Due to Another Medical Condition
Catatonia	Catatonia Associated with Another Mental Disorder (Catatonia Specifier) Catatonic Disorder Due to Another Medical Condition Unspecified Catatonia
Bipolar and Related Disorders	Bipolar I Disorder Bipolar II Disorder Cyclothymic Disorder Substance/Medication-Induced Bipolar and Related Disorder Bipolar and Related Disorder Due to Another Medical Condition Other Specified Bipolar and Related Disorder Unspecified Bipolar and Related Disorder
Depressive Disorders	Disruptive Mood Dysregulation Disorder Major Depressive Disorder, Single and Recurrent Episodes Persistent Depressive Disorder (Dysthymia) Premenstrual Dysphoric Disorder Substance/Medication-Induced Depressive Disorder Depressive Disorder Due to Another Medical Condition Other Specified Depressive Disorder Unspecified Depressive Disorder
Anxiety Disorders	Separation Anxiety Disorder Selective Mutism Specific Phobia

	Social Anxiety Disorder (Social Phobia) Panic Disorder Panic Attack (Specifier) Agoraphobia Generalized Anxiety Disorder Substance/Medication-Induced Anxiety Disorder Anxiety Disorder Due to Another Medical Condition Other Specified Anxiety Disorder Unspecified Anxiety Disorder
Obsessive-Compulsive and Related Disorders	Obsessive-Compulsive Disorder Body Dysmorphic Disorder Hoarding Disorder Trichotillomania (Hair-Pulling Disorder) Excoriation (Skin-Picking) Disorder Substance/Medication-Induced Obsessive-Compulsive and Related Disorder Obsessive-Compulsive and Related Disorder Due to Another Medical Condition Other Specified Obsessive-Compulsive and Related Disorder Unspecified Obsessive-Compulsive and Related Disorder
Trauma- and Stressor-Related Disorders	Reactive Attachment Disorder Disinhibited Social Engagement Disorder Posttraumatic Stress Disorder Acute Stress Disorder Adjustment Disorders Other Specified Trauma- and Stressor-Related Disorder Unspecified Trauma- and Stressor-Related Disorder
Dissociative Disorders	Dissociative Identity Disorder Dissociative Amnesia Depersonalization/Derealization Disorder Other Specified Dissociative Disorder Unspecified Dissociative Disorder
Somatic Symptom and Related Disorders	Somatic Symptom Disorder Illness Anxiety Disorder Conversion Disorder (Functional Neurological Symptom Disorder) Psychological Factors Affecting Other Medical Conditions Factitious Disorder

	Other Specified Somatic Symptom and Related Disorder Unspecified Somatic Symptom and Related Disorder
Feeding and Eating Disorders	Pica Rumination Disorder Avoidant/Restrictive Food Intake Disorder Anorexia Nervosa Bulimia Nervosa Binge-Eating Disorder Other Specified Feeding or Eating Disorder Unspecified Feeding or Eating Disorder
Elimination Disorders	Enuresis Encopresis Other Specified Elimination Disorder Unspecified Elimination Disorder
Sleep-Wake Disorders	Insomnia Disorder Hypersomnolence Disorder Narcolepsy
Breathing-Related Sleep Disorders	Obstructive Sleep Apnea Hypopnea Central Sleep Apnea Sleep-Related Hypoventilation Circadian Rhythm Sleep-Wake Disorders
Parasomnias	Non–Rapid Eye Movement Sleep Arousal Disorders Sleepwalking Sleep Terrors Nightmare Disorder Rapid Eye Movement Sleep Behavior Disorder Restless Legs Syndrome Substance/Medication-Induced Sleep Disorder Other Specified Insomnia Disorder Unspecified Insomnia Disorder Other Specified Hypersomnolence Disorder Unspecified Hypersomnolence Disorder Other Specified Sleep-Wake Disorder Unspecified Sleep-Wake Disorder
Sexual Dysfunctions	Delayed Ejaculation Erectile Disorder Female Orgasmic Disorder

	Female Sexual Interest/Arousal Disorder Genito-Pelvic Pain/Penetration Disorder Male Hypoactive Sexual Desire Disorder Premature (Early) Ejaculation Substance/Medication-Induced Sexual Dysfunction Other Specified Sexual Dysfunction Unspecified Sexual Dysfunction
Gender Dysphoria	Gender Dysphoria Other Specified Gender Dysphoria Unspecified Gender Dysphoria
Disruptive, Impulse-Control, and Conduct Disorders	Oppositional Defiant Disorder Intermittent Explosive Disorder Conduct Disorder Antisocial Personality Disorder Pyromania Kleptomania Other Specified Disruptive, Impulse-Control, and Conduct Disorder Unspecified Disruptive, Impulse-Control, and Conduct Disorder
Substance-Related and Addictive Disorders Substance-Related Disorders	Substance Use Disorders Substance-Induced Disorders Substance Intoxication and Withdrawal Substance/Medication-Induced Mental Disorders
Alcohol-Related Disorders	Alcohol Use Disorder Alcohol Intoxication Alcohol Withdrawal Other Alcohol-Induced Disorders Unspecified Alcohol-Related Disorder
Caffeine-Related Disorders	Caffeine Intoxication Caffeine Withdrawal Other Caffeine-Induced Disorders Unspecified Caffeine-Related Disorder
Cannabis-Related Disorders	Cannabis Use Disorder Cannabis Intoxication Cannabis Withdrawal Other Cannabis-Induced Disorders Unspecified Cannabis-Related Disorder

Hallucinogen-Related Disorders	Phencyclidine Use Disorder Other Hallucinogen Use Disorder Phencyclidine Intoxication Other Hallucinogen Intoxication Hallucinogen Persisting Perception Disorder Other Phencyclidine-Induced Disorders Other Hallucinogen-Induced Disorders Unspecified Phencyclidine-Related Disorder Unspecified Hallucinogen-Related Disorder
Inhalant-Related Disorders	Inhalant Use Disorder Inhalant Intoxication Other Inhalant-Induced Disorders Unspecified Inhalant-Related Disorder
Opioid-Related Disorders	Opioid Use Disorder Opioid Intoxication Opioid Withdrawal Other Opioid-Induced Disorders Unspecified Opioid-Related Disorder
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders	Sedative, Hypnotic, or Anxiolytic Use Disorder Sedative, Hypnotic, or Anxiolytic Intoxication Sedative, Hypnotic, or Anxiolytic Withdrawal Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
Stimulant-Related Disorders	Stimulant Use Disorder Stimulant Intoxication Stimulant Withdrawal Other Stimulant-Induced Disorders Unspecified Stimulant-Related Disorder
Tobacco-Related Disorders	Tobacco Use Disorder Tobacco Withdrawal Other Tobacco-Induced Disorders Unspecified Tobacco-Related Disorder

Other (or Unknown) Substance–Related Disorders	Other (or Unknown) Substance Use Disorder Other (or Unknown) Substance Intoxication Other (or Unknown) Substance Withdrawal Other (or Unknown) Substance–Induced Disorders Unspecified Other (or Unknown) Substance–Related Disorder
Non-Substance-Related Disorders	Gambling Disorder
Neurocognitive Disorders	Delirium Other Specified Delirium Unspecified Delirium
Major and Mild Neurocognitive Disorders	Major Neurocognitive Disorder Mild Neurocognitive Disorder Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease Major or Mild Frontotemporal Neurocognitive Disorder Major or Mild Neurocognitive Disorder With Lewy Bodies Major or Mild Vascular Neurocognitive Disorder Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury Substance/Medication-Induced Major or Mild Neurocognitive Disorder Major or Mild Neurocognitive Disorder Due to HIV Infection Major or Mild Neurocognitive Disorder Due to Prion Disease Major or Mild Neurocognitive Disorder Due to Parkinson's Disease Major or Mild Neurocognitive Disorder Due to Huntington's Disease Major or Mild Neurocognitive Disorder Due to Another Medical Condition Major or Mild Neurocognitive Disorder Due to Multiple Etiologies Unspecified Neurocognitive Disorder
Personality Disorders	General Personality Disorder

Cluster A Personality Disorders	Paranoid Personality Disorder Schizoid Personality Disorder Schizotypal Personality Disorder
Cluster B Personality Disorders	Antisocial Personality Disorder Borderline Personality Disorder Histrionic Personality Disorder Narcissistic Personality Disorder
Cluster C Personality Disorders	Avoidant Personality Disorder Dependent Personality Disorder Obsessive-Compulsive Personality Disorder
Other Personality Disorders	Personality Change Due to Another Medical Condition Other Specified Personality Disorder Unspecified Personality Disorder
Paraphilic Disorders	Voyeuristic Disorder Exhibitionistic Disorder Frotteuristic Disorder Sexual Masochism Disorder Sexual Sadism Disorder Pedophilic Disorder Fetishistic Disorder Transvestic Disorder